

My Emergency Information

Name _____ Date of Birth _____

Address _____

City _____

City _____

Zip _____



EMERGENCY CONTACTS

Name _____

Relation _____

Phone _____

Name _____

Relation _____

Phone _____

MEDICAL DATA

Last Updated (Month/Year) _____

Blood Type _____

Physician _____

Phone _____

Physician _____

Phone _____

Insurance Carrier _____

Insurance Carrier _____

Medicare Participant

YES

NO

If YES, do you have a Part D Plan? YES

NO



(800) 699-9043

ageoptions.org

Medication	Dosage	Frequency

ALLERGIES

- | | |
|--|--|
| <input type="checkbox"/> Aspirin
<input type="checkbox"/> Barbiturate
<input type="checkbox"/> Codeine
<input type="checkbox"/> Demerol
<input type="checkbox"/> Insect Stings
<input type="checkbox"/> Latex
<input type="checkbox"/> Lidocaine | <input type="checkbox"/> Morphine
<input type="checkbox"/> Novocaine
<input type="checkbox"/> Penicillin
<input type="checkbox"/> Sulfa
<input type="checkbox"/> Tetracycline
<input type="checkbox"/> X-Rays Dyes
<input type="checkbox"/> No Known Allergies |
|--|--|

Environmental: _____

Other: _____

Advanced Medical Directives

Living Will on file at:
Power of Attorney Healthcare:
Phone:
Do you have a DO NOT RESUSCITATE form? <input type="checkbox"/> YES <input type="checkbox"/> NO Where is it located?