KEEP INFORMATION UP TO DATE

Name: Sex: M F

Address: Date of Birth: / /

Own Guardian? YES NO (if NO, fill in below)

Guardian Name:

Address:

Emergency Phone #:

Guardianship Status (full, limited, etc.):

EMERGENCY CONTACTS

Name:

Address:

Emergency Phone #:
Relation:

Name:

Address:

Emergency Phone #:
Relation:

ALARM COMPANY

Phone #/Pass Code for Alarm Company:

"POINT OF SAFETY"

Identify the safe place outside your home you would go in case of a fire (e.g.; neighbors driveway, tree at end of block, mailbox, etc.)?:

COMMUNICATION
("X" all areas that apply)

( ) Cannot Speak English Language:	( ) Non-Verbal
( ) Uses Sign Language	( ) Uses Communication Device(s)

Religion:
Living Will on file at:
Health Care Proxy on file at:
Do you have a DNR Form? YES ☐ NO ☐ Where is it located?

Medical Data

Last Updated: Mo Year	Blood Type:
Doctor:	Phone #:
Doctor:	Phone #:

Medications	

Recent Surgeries	**Date**

MEDICAL CONDITIONS (check all that exist)

( ) No known medical conditions
( ) Abnormal EKG ( ) Angina
( )Adrenal Insufficiency ( ) Asthma
( ) Bleeding Disorder ( ) Cardiac Dysrhythmia
( ) Clotting Disorder ( ) Coronary Bypass Graft
( ) Dementia ( ) Alzheimer's
( ) Memory Impaired
( ) Hypoglycemia ( ) Diabetes/Insulin Dependent
( ) Cataracts ( ) Eye Surgery ( ) Glaucoma
( ) Heart Valve Prosthesis ( ) Pacemaker
( ) Hemodialysis ( ) Hemolytic Anemia
( ) Hypertension ( ) Laryngectomy
( ) Leukemia ( ) Lymphomas
( ) Malignant Hypothermia ( ) Myasthenla Gravis
( ) Renal Failure ( ) Seizure Disorder
( ) Sickle Cell Anemia ( ) Stroke
( ) Hearing Impaired ( ) Vision Impaired
( ) Blind ( ) Deaf
( ) Other

_____
_____
_____
_____

ALLERGIES (medication, food, other…)

MEDICAL INSURANCE

Med Ins Company:

Policy #:

Other Med Ins Company:

Policy #:

Medicaid #:

Medicare #: