Name: _____ **As of Date:** _____

Address: _____
Phone(s) _____
Email address: _____

Born: Date: _____, Where: _____ Age: _____
Sex: Female Race: _____ Hair: _____ Eyes: _____
Height: _____ Weight: _____ Blind: _____ Glasses: _____Contacts: _____
Dentures: ____ Mute: _____ Deaf: _____ Hearing Aid: _____

Native Language: _____ Religion: _____
Social Security Number: _____
Doctor's Name: _____ Phone: _____
Insurance: _____

Allergies to Medications: _____
Other Allergies: _____
Medications/Location: _____
Pacemaker: _____ Organ Donor: _____

Yes or No to:

AIDS	Anemia	Arthritis
Asthma	Cancer	Diabetes
Dialysis	Epilepsy	Glaucoma
Heart Condition	Hepatitis	High Blood Pressure
Respiratory	Sickle Cell	Stroke
Tuberculosis		

Advance Directives/Location: _____.

Local Emergency Contact: _____

Work/Phone: _____

_____

Family:

For each provide name, relationship, address, phone numbers, email address

Partner:_____

Children:_____

Parents:_____

Other:_____

Please keep this information in or on your refrigerator and update it at least once a year. *When you are away*, please leave dates, location, and contact information on your refrigerator door. **Form Date: 12/28/09**

Medications/Additional Information:

For medications include:

Name, Dosage, Frequency, Why taking it, Dr who prescribed it
Allergies to any medications

Other Information:

Anything else a treatment center would need to know in case you were unconscious and couldn't provide the information yourself.

Please keep this information in or on your refrigerator and update it at least once a year. *When you are away*, please leave dates, location, and contact information on your refrigerator door. **Form Date: 12/28/09**