



Help us help you form.

Please fill in as much information as you can in the fields below.

Fold and place in the envelope provided.

First name:	Last name:
Date of birth:	

What medical problems do you have: (Check all that apply)

O Asthma/COPD/Emphysema	O Pacemaker/Implanted Defibrillator
O _{Cancer}	Other. Please list:
O _{Diabetes}	
O Heat Problems	
O High Blood Pressure	
Oseizures	
Ostrokes	

What medications do you take?

Drug name	Dose	Drug name	Dose

What allergies do you have?

O No known allergies
Allergies:

Who is your emergency contact?

Name:	Home phone:
Relationship:	Cell phone:

Who are your doctors?

Doctor's name	Specialty	Phone number

What hospitals do you go to?

Is there any other information that we may need to know?

**Place in a visible area in your house. Please remember to update your information every 6 months or after any changes.