ATTACHMENT I
MEDICAL INFORMATION

Name _____ **Address** _____

City _____ **State** _____ **Zip Code** _____ **Home phone** _____

Work phone _____ **Cell phone** _____ **Email** _____

Date of Birth _____ **Blood Type** _____

Please check all that apply:

Contact lenses _____ Dentures _____ Diabetic _____ Epileptic _____ Metal in body _____

Additional information: _____

Allergies to medications? _____ Please list _____

List all medical conditions: _____

_____

Next of kin or person to be notified in an emergency:

Name _____ Relationship _____ Phone _____

Email _____

Name _____ Relationship _____ Phone _____

Email _____

Name _____ Relationship _____ Phone _____

Email _____

NOTE: INFORMATION ON NEXT PAGE IS VOLUNTARY BUT MAY BE USED TO ASSIST IN EMERGENCY!

Medicare Beneficiary? Yes ____ No ____ **Medicare Part D?** Yes ____ No ____ **Medicare #** _____

Supplementary/Insurance Company _____ **Phone** _____

Group # _____ **Policy #** _____

Preferred Hospital: _____

Primary physician and/or medical treatment facility:

Physician Name _____ Phone _____

Medication List *Include over-the-counter, vitamins and prescription medications*

Rx Name	Dose