Health ICE©

Health Information - In Case of Emergency

Date Filled Out: _____

Name: _____
Address: _____
Phone: _____
Birth Date: _____
Male: _____ Female: _____
Social Security Number: _____
Blood Type: _____
Distinguishing Features: _____
Glasses? Y N Contacts? Y N
Hearing Aid? Y N Dentures? Y N
Pacemaker? Y N Model _____
Prosthesis? Y N
Living Will? Y N
Signed Donor Card? Y N

In Case of Emergency, Please Notify:
Name: _____
Address: _____
Day/Night Phone: _____
Relation: _____

Insurance:
Medicare Number: _____
Medicaid Number: _____
Medicare D Plan: _____

Health Information:
Allergies to Medications: _____
_____
_____
Other Allergies: _____
Doctors: Phone:
_____
_____
_____

Pharmacies: Phone:
_____
_____
_____

Medical Conditions:
___ Heart Disease
___ Rheumatic Fever
___ Blood pressure
___ Tuberculosis (TB)
___ Ulcers
___ Lung Disease
___ Asthma/Hay Fever
___ Diabetes
___ Epilepsy
___ Parkinson Disease
___ Nervous Disorders
___ Jaundice
___ Hepatitis
___ Arthritis
___ Stroke
___ Cataract / Glaucoma
___ Transplant

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Current Medications, Vitamins & Supplements:
Draw a line through the item when it is changed or stopped. Enter the date of the change.

	Name & Strength	How taken or used
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		

Improving the quality of life of seniors and others by supporting better use of their medications

Lynn Harrelson, Senior Care Pharmacist
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