

Health ICE® Senior Pharmacy Solutions

Health Information - In Case of Emergency

Date Filled Out: _____

Name: _____

Address: _____

Phone: _____

Birth Date: _____

Male: _____ Female: _____ Religion: _____

Social Security Number: _____

Blood Type: _____

Distinguishing Features: _____

Glasses? Y N Contact 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 ___ Parkinson Disease

___ Rheumatic Fever ___ Nervous Disorders

___ Blood pressure ___ Jaundice

___ Ulcers ___ Hepatitis

___ Tuberculosis (TB) ___ Arthritis

___ Lung Disease ___ Stroke

___ Emphysema/COPD ___ Glaucoma

___ Asthma/Hay Fever ___ Cataract

___ Diabetes ___ Transplant

___ Epilepsy ___ Anemia

___ Broken Bones, Where _____

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Current Medications, Vitamins and Supplements:

**Draw a line through the item when it is changed or stopped.
Enter the date of the change.**

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



**Assisting seniors and others in
improving their quality of life by
supporting better use of their medications**