ICE Medical and Contact Information

Name (Person 1) _____

Home Address _____

Date form completed _____ **Date updated** _____ **Phone** _____

DOB _____ **Sex M/F** _____

SSN _____ **Weight** _____

Hospital preference _____ **Religion** _____

Doctor _____ **Blood type** _____

Language _____

Living Will Y N _____ **Location** _____

INSURANCE INFORMATION AND NUMBER

Medicare _____

Medicaid _____

Other _____

MEDICAL INFORMATION

Food/Drug allergies _____

_____

PRESCRIBED MEDICATIONS AND SUPPLEMENTS

Name	Dosage	Times/Day	AM/PM

Location of meds _____

Pharmacy _____ **Date updated** _____

MEDICAL HISTORY

Blind	**Y N**	**L R B**	**Pacemaker**	**Y N**
Hearing aid	**Y N**	**L R B**	**Glasses**	**Y N**
Dentures	**Y N**	**L U B**	**Contacts**	**Y N**
Deaf	**Y N**	**L R B**	**Dementia**	**Y N**
Mute	**Y N**		**Dialysis**	**Y N**
HIV/AIDS	**Y N**		**Diabetes**	**Y N**
Arthritis	**Y N**		**Epilepsy**	**Y N**
Cancer	**Y N**		**Glaucoma**	**Y N**
Stroke	**Y N**		**TB**	**Y N**

Anemia Y N Type _____

Cardiac Y N Type _____

Hepatitis Y N Type _____

Respiratory Y N Type _____

Abnormal blood pressure Y N HI/LO _____ / _____

Are you an organ donor? Y N

Are you a caregiver? Y N

Do you pick someone up from school, daycare, etc.? Y N

Do you have a pet at home? Y N

Do you have a healthcare surrogate? Y N

Name _____ **Phone** _____

Do not resuscitate order Y N Location _____

COPY OF DRIVERS LICENSE

COPY OF INSURANCE CARD

EMERGENCY CONTACT 1

Name _____

Address _____

Phone _____

Cell _____

Relationship _____

Employment _____

EMERGENCY CONTACT 2

Name _____

Address _____

Phone _____

Cell _____

Relationship _____

Employment _____

Place this form in red vinyl pouch.

Turn over for person 2.

ICE Medical and Contact Information

Name (Person 2) _____

Home Address _____

Date form completed _____ **Date updated** _____ **Phone** _____

DOB _____ **Sex M/F** _____
SSN _____ **Weight** _____
Hospital preference _____ **Religion** _____
Doctor _____ **Blood type** _____
Language _____
Living Will Y N _____ **Location** _____

INSURANCE INFORMATION AND NUMBER

Medicare _____
Medicaid _____
Other _____

MEDICAL INFORMATION

Food/Drug allergies _____

_____

PRESCRIBED MEDICATIONS AND SUPPLEMENTS

Name	Dosage	Times/Day	AM/PM

Location of meds _____
Pharmacy _____ **Date updated** _____

MEDICAL HISTORY

Blind	**Y N**	**L R B**	**Pacemaker**	**Y N**
Hearing aid	**Y N**	**L R B**	**Glasses**	**Y N**
Dentures	**Y N**	**L U B**	**Contacts**	**Y N**
Deaf	**Y N**	**L R B**	**Dementia**	**Y N**
Mute	**Y N**		**Dialysis**	**Y N**
HIV/AIDS	**Y N**		**Diabetes**	**Y N**
Arthritis	**Y N**		**Epilepsy**	**Y N**
Cancer	**Y N**		**Glaucoma**	**Y N**
Stroke	**Y N**		**TB**	**Y N**

Anemia Y N Type _____
Cardiac Y N Type _____
Hepatitis Y N Type _____
Respiratory Y N Type _____
Abnormal blood pressure Y N HI/LO _____ / _____
Are you an organ donor? Y N
Are you a caregiver? Y N
Do you pick someone up from school, daycare, etc.? Y N
Do you have a pet at home? Y N
Do you have a healthcare surrogate? Y N
Name _____ **Phone** _____
Do not resuscitate order Y N Location _____

COPY OF DRIVERS LICENSE

COPY OF INSURANCE CARD

EMERGENCY CONTACT 1

Name _____
Address _____
Phone _____
Cell _____
Relationship _____
Employment _____

EMERGENCY CONTACT 2

Name _____
Address _____
Phone _____
Cell _____
Relationship _____
Employment _____

Place this form in red vinyl pouch.

Turn over for person 1.