

Grace-Full Seniors Emergency Medical Information

(good through 12/31/17)

Name: _____

Address: _____

City, State, Zip Code: _____

Telephone: _____

(home) _____ (cell) _____

Birthday: _____

Living Will? Yes No Donor? Yes No Durable Power of Attorney for Health Care? Yes No

IN CASE OF EMERGENCY PLEASE NOTIFY:

Name: _____

Address: _____

City, State, Zip Code: _____

Telephone: _____

(home) _____ (cell) _____

Relationship: _____

MEDICAL INFORMATION:

Medical Condition (Heart, Diabetes, etc): _____

Last Tetanus Shot: _____ Blood Type: _____

Allergies (Penicillin, Sulfa, etc): _____

I am taking the following medications: _____

INSURANCE INFORMATION:

Company Name: _____

Policy Number: _____

Phone Number: _____

Dr. Name: _____

Phone Number: _____

For Living Will or Donor Information call: _____