Member enrollment

Last name _____

First name _____

Nickname _____

Address *(no PO Boxes)* _____

City _____

State _____ ZIP code _____

Phone (_____) _____

Birth date _____ ❑ Male ❑ Female

Last 4 digits of Social Security No. _____

Height _____ Weight _____

Eye color _____ Hair color _____

Race/ethnicity _____

Skin tone ❑ Dark ❑ Medium ❑ Fair

❑ Mole ❑ Tattoo ❑ Scar ❑ Birth mark

_____

Drug allergies

List all known drug allergies.

_____

_____

Medications

List all medications and dosages, including inhalers.

Medication	Prescribed Dosage

Medical conditions

Only individuals with Alzheimer's or a related dementia are eligible for the MedicAlert + Safe Return program.

❑ Alzheimer's disease

❑ Other dementia _____

Other conditions

❑ Angina
❑ Arthritis
❑ Asthma
❑ Atrial Fibrillation
❑ Chronic Obstructive Pulmonary Disease (COPD)
❑ Congestive Heart Failure
❑ Coronary Artery Disease
❑ Diabetes
❑ Emphysema
❑ Epilepsy
❑ Glaucoma
❑ Hearing Impaired
❑ Hypertension
❑ Myocardial Infarction
❑ Organ Transplant
❑ Seizure Disorder
❑ Stroke
❑ Von Willebrand's Disease

❑ Other _____

❑ Implant* _____

Primary contact information

Last name _____

First name _____

Address *(no PO Boxes)* _____

City _____

State _____ ZIP code _____

Phone home (_____) _____

Cell (_____) _____

Work (_____) _____

Email _____

* Please list the manufacturer model and serial number, or include a copy of your implant card with this form.

Secondary contact information

Last name _____

First name _____

Address *(no PO Boxes)* _____

City _____

State _____ ZIP code _____

Phone home (_____) _____

Cell (_____) _____

Work (_____) _____

Email _____

Optional $35 caregiver enrollment

Last name _____

First name _____

Nickname _____

Address *(no PO Boxes)* _____

City _____

State _____ ZIP code _____

Phone home (_____) _____

Cell (_____) _____

Work (_____) _____

Birth date _____ ❑ Male ❑ Female

Last 4 digits of Social Security No. _____

Drug allergies

List all known drug allergies.

_____

_____

Medications

List all medications and dosages, including inhalers.

Medication	Prescribed Dosage

Medical conditions

Check the box next to each of your conditions and write in any others. While these conditions are very important, any condition that requires continued physician care or special attention in an emergency should be noted.

- ❑ Angina
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ Chronic Obstructive Pulmonary Disease (COPD)
- ❑ Congestive Heart Failure
- ❑ Coronary Artery Disease
- ❑ Diabetes
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Glaucoma
- ❑ Hearing Impaired
- ❑ Hypertension
- ❑ Myocardial Infarction
- ❑ Organ Transplant
- ❑ Seizure Disorder
- ❑ Stroke
- ❑ Von Willebrand's Disease

❑ Other _____

❑ Implant* _____

❑ No known medical conditions

Emergency contact

Last name _____

First name _____

Nickname _____

Phone home (_____) _____

Cell (_____) _____

Work (_____) _____