SENIOR CONTACT AND MEDICATION TEMPLATE *UPDATED ON:_____*

Legal Name:	**Date of Birth:**
Preferred Language:	**Blood Type:**

I have ◯ HEARING AID ◯ DENTURES ◯ TAKING INSULIN ◯ EYE GLASSES ◯ CONTACT LENSES

Optional Information: ◯ LEGALLY/TOTALLY BLIND ◯ DEAF

Disabled: ◯ WHEELCHAIR BOUND ◯ USE A CANE ◯ SERVICE ANIMAL ◯ PROSTHESIS

EMERGENCY CONTACT				
NAME	**RELATIONSHIP**	**ADDRESS**	**HOME/WORK/CELL NUMBERS**	**EMAIL**

PHYSICIAN AND HEALTH CARE INFORMATION		
Primary Physician Name:	Phone Number:	Preferred Hospital:
Specialist Name:	Phone Number:	Preferred Pharmacy:

LIST OF CURRENT MEDICATIONS		
NAME OF MEDICATION/OTC	**DOSAGE**	**NUMBER OF TIME TAKEN/DAY**

LIST ANY MEDICAL CONDITIONS (EXAMPLE: DIABETES, AIDS, ALZHEIMER'S/DEMENTIA)			

Do you have a DNR? ◯ YES ◯ NO Location of DNR: _____

List ANY know allergies: _____

Medicines are located in the: ◯ KITCHEN ◯ BATHROOM ◯ REFRIGERATOR ◯ OTHER _____