

HEALTH INFORMATION FORM

NAME (First, Middle, Last)			DATE OF BIRTH		GENDER	FIRST LANGUAGE		FORMUPDATED ON (date)	
HOME ADDRESS			PHONE NUMBER			HEIGHT / WEIGHT			
HOSPITAL OF CHOICE			SOCIAL SECURITY #						
NEEDS CAREGIVER/SUPPORT PERSON									
ALLERGIES	ACCESSIBILITY	Mobility Assistance (walker, cane, wheelchair)				OXYGEN			
		Sensory Sensitivities				Device			
						Supplier			
						Settings			
		Deaf or Hard Of Hearing				FEEDINGS			
		Hearing Aides				Model			
		Communication Device				Brand			
		Blind or low vision				Mode			
		Glasses				Frequency			
		Intellectual or				Amount			
Developmental Disability				Rate					
MEDICAL AND SURGICALHISTORY	OVER THE COUNTER & PRESCRIBED MEDICATION LIST	MEDICATION		DOSE	TIME	ROUTE	SUPPLIES		PRESCRIBING PROVIDER
IMPLANTED MEDICAL DEVICES									

HEALTH INFORMATION

IMPORTANT NUMBERS

RESOURCE / NAME	PHONE NUMBER
EMERGENCY	911
Marion County Police Non-Emergency	311 or 3 1 7 - 3 2 7 - 3 8 1 1
Poison Control	1 - 8 0 0 - 2 2 2 - 1 2 2 2
Be Well Indiana	211
Suicide and Crisis Hotline Call or Text	988
Veterans Crisis Line	988 & Press 1 or Text 838255
Safe Call Now	2 6 0 - 4 5 9 - 3 0 2 0
Medical Power of Attorney:	
Emergency Contact #1:	
Emergency Contact #2:	
Primary Care Physician or Nurse Practitioner:	
Specialist:	
Specialist:	
Specialist:	
Specialist:	
Eye Doctor:	
Dentist:	
Insurance Agent:	
Policy Number:	

COPY OF IDENTIFICATION

COPY OF INSURANCE CARD

COPY OF MEDICAL DEVICE IMPLANT
CARD

COPY OF GLASSES PRESCRIPTION

Other Info: