This Card Could Save Your Life!

IN AN EMERGENCY DIAL 911

Complete this card & place on your refrigerator for referral in case of medical emergency and/or 911 response.

Name: _____

Address: _____

City _____ ***State*** _____ ***Zip*** _____

Contacts (Name & Phone #'s):

1. _____ ***C:*** _____ ***H:*** _____

2. _____ ***C:*** _____ ***H:*** _____

3. _____ ***C:*** _____ ***H:*** _____

Primary Doctor's Name: _____

Doctor 's Phone: _____

Health Care Plan & #'s: _____

Medicare #: _____

Date Card Completed: _____

Telephone: ( ) _____

Allergies: _____

_____

Date of Birth: _____

Social Security #: _____

Major Illnesses: _____

_____

_____

Other important information for first responders to know:

_____

_____

(Over for Medications)

The Option Group, LLC
11019 McCormick Rd., Suite 260
Hunt Valley, MD 21031
http://theoptiongroup.net

AGING life CARE™ ASSOCIATION MEMBER

For more information, contact:
Ellen S. Platt, MEd, CRC, CCM
eplatt@theoptiongroup.net

Wallet Card For You

This Wallet Card Could Save Your Life!

Name: _____
Address: _____
Telephone: _____
Emergency Contact Person: _____
Relationship: _____
Phone C: _____ ***H:*** _____
Emergency Contact Person: _____
Relationship: _____
Phone C: _____ ***H:*** _____
Primary Doctor: _____
Phone: _____

FOLD

Health Care Plan: _____
Medicare #: _____
Allergies to Medications: _____
Other Allergies: _____
Major Illnesses: _____
Preferred Hospital: _____

The OPTION GROUP Clear choices. Better care.

Cut on the dotted lines. Complete the information. Fold in the Middle. Put in your wallet

Extra Wallet Card For Spouse Or Friend

This Wallet Card Could Save Your Life!

Name: _____
Address: _____
Telephone: _____
Emergency Contact Person: _____
Relationship: _____
Phone C: _____ ***H:*** _____
Emergency Contact Person: _____
Relationship: _____
Phone C: _____ ***H:*** _____
Primary Doctor: _____
Phone: _____

FOLD

Health Care Plan: _____
Medicare #: _____
Allergies to Medications: _____
Other Allergies: _____
Major Illnesses: _____
Preferred Hospital: _____

The OPTION GROUP Clear choices. Better care.

Cut on the dotted lines. Complete the information. Fold in the Middle. Give To Friend, Caregiver, or Spouse.

MEDICATIONS

CURRENT MEDICATIONS	DOSAGE STRENGTH	HOW OFTEN TAKEN	PRESCRIBED BY

Date of Last Shots/Inoculations	
Flu:	*/ / 20___*
Pneumonia:	*/ / 20___*
Other, Type:	*/ / 20___*

Hearing Aids		
Yes	*No*	*Date Last Updated :*

Glasses		
Yes	*No*	*Date Last Updated :*

Dentures		
Yes	*No*	

P ac emak er		
Yes	*No*	*Model No:*

Extra Wallet Card For Spouse Or Friend

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CURRENT MEDICATIONS	DOSAGE	WHEN TAKEN

OTHER IMPORTANT INFORMATION FOR FIRST RESPONDERS TO KNOW

Cut on the dotted lines. Complete the information. Fold in the Middle. Give To Friend, Caregiver, or Spouse.

Wallet Card For You

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CURRENT MEDICATIONS	DOSAGE	WHEN TAKEN

OTHER IMPORTANT INFORMATION FOR FIRST RESPONDERS TO KNOW