**I.C.E.: I**n **C**ase of **E**mergency

We need your information filled out below. This will be for the Office only! Your cell numbers will not be publicized unless you ask for it to be.

**COR EMERGENCY INFORMATION SHEET**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1st ICE Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2nd ICE Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_# \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Med Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Shellfish Allergy: Yes, No, Not Sure (circle)

Major Medical conditions: (circle) Diabetes, TIA, stroke, seizures, heart \_\_\_\_\_\_\_\_\_\_\_\_(list), lung (list)\_\_\_\_\_\_\_\_\_\_\_\_\_\_, autoimmune\_\_\_\_\_\_\_\_\_\_\_\_\_, passing out (reason)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, memory issues, on blood thinners, other  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Major Surgeries: heart \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, lung\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, carotid, other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physicians\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other specific instructions: such as current list of meds in my wallet (for example) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any residual impairments? Like weakness on \_\_\_\_ side of body. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have an advanced directive (circle) Yes / No? If so where is it located? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I authorize this information to be used on my behalf in case of emergency. My medical information may be shared with those providing medical care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(signature)