Member enrollment

MedicAlert FOUNDATION

Last name _____

First name _____

Nickname _____

Address *(no PO Boxes)* _____

City _____ State _____

Apt.# _____ ZIP code _____

Date of birth _____

Phone _____

❑ Male ❑ Female ❑ Male to Female ❑ Female to Male

Last four digits of Social Security No. _____

Height _____ Weight _____

Eye color _____ Hair color _____

Race/Ethnicity _____

Language Spoken _____

Skin tone ❑ Dark ❑ Medium ❑ Fair

❑ Mole ❑ Tattoo ❑ Scar ❑ Birth mark

Primary Doctor Name _____

Primary Doctor Phone _____

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 this program.

❑ Alzheimer's disease

❑ Other Dementia _____

OTHER CONDITIONS

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

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

_____ _____

_____ _____

_____ _____

PRIMARY CONTACT INFORMATION

Last name _____

First name _____

Address *(no PO Boxes)* _____

City _____ State _____

Apt.# _____ ZIP code _____

Home Phone _____

Cell Phone _____

Work Phone _____

Email _____

Relationship _____

SECONDARY CONTACT INFORMATION

Last name _____

First name _____

Address *(no PO Boxes)* _____

City _____ State _____

Apt.# _____ ZIP code _____

Home Phone _____

Cell Phone _____

Work Phone _____

Email _____

Relationship _____

CAREGIVER ENROLLMENT

Last name _____

First name _____

Address *(no PO Boxes)* _____

City _____ State _____

Apt.# _____ ZIP code _____

Date of birth _____

Home Phone _____

Cell Phone _____

Work Phone _____

❑ Male ❑ Female ❑ Male to Female ❑ Female to Male

Last four digits of Social Security No. _____

Language Spoken _____

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 the others. While these conditions are very important, any condition that requires continued physician care or special attention in an emergency should be noted.
*(*Please list the manufacturer model and serial number, or include a copy of the implant card with this form.)*

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

_____ _____

_____ _____

EMERGENCY CONTACT

Last name _____

First name _____

Home Phone _____

Cell Phone _____

Work Phone _____

Relationship _____

Member ID jewelry & payment

MEDICALERT® ID OPTIONS

A091
Large Classic Red Bracelet

A126
Small Classic Red Bracelet

A721
Classic Red Necklace

BACK OF MEDICALERT® ID

MEMBER CAREGIVER

Other MedicAlert IDs are available at additional cost. A complete selection is available online at www.medicalert.org/medicalids.

Measure wrist for bracelet:

Determine wrist size, or put a string around wrist and measure it against a ruler. (Please add ½" for comfort.)

MEMBER JEWELRY SELECTION

❑ A091 - Large red stainless steel bracelet (1 5/8")
❑ A126 - Small red stainless steel bracelet (1 3/8")
❑ A721 - Red stainless steel necklace (1 1/4") with 26" chain

Exact wrist measurement _____ inches
(Required for bracelet. Please measure wrist snugly and add 1/2")

CAREGIVER JEWELRY SELECTION
(If purchasing caregiver membership)

❑ A091 - Large red stainless steel bracelet (1 5/8")
❑ A126 - Small red stainless steel bracelet (1 3/8")
❑ A721 - Red stainless steel necklace (1 1/4") with 26" chain

Exact wrist measurement _____ inches
(Required for bracelet. Please measure wrist snugly and add 1/2")

RECENT PHOTO OF MEMBER PROVIDED?

❑ Yes ❑ No

(Send original photo, passport size or larger. Photo will not be returned. Please write member's name on back of photo.)

ID ENGRAVING: In an emergency, response personnel need to be aware of the member's critical medical information in order to treat the member correctly. A MedicAlert medical ID will be engraved with their member identification number and our live 24/7 emergency response number to enable responders to assist the member immediately.

PLEASE NOTE: Once the MedicAlert ID has been engraved and shipped, there will be an additional charge for any changes requested. ID engraving is personalized to individual members and cannot be transferred to another individual, altered, sold, or returned. To help assure you receive thorough, accurate treatment, the condition our trained staff deems most relevant to the member's medical needs in an immediate emergency treatment will be engraved on the ID.

Organization _____

MAIL TO: MedicAlert Foundation
5226 Pirrone Court
Salida, CA 95368

1-800-432-5378 | **www.medicalert.org**

SHIPPING & HANDLING

❑ USPS Standard (Does not include tracking) - $9
❑ USPS Priority - $12
❑ FedEx Ground - $15
❑ FedEx 2-Day - $22

PAYMENT

❑ Check *(Payable to MedicAlert Foundation)*

CONSENT

Important: By accepting membership in MedicAlert Foundation, for yourself as member or caregiver and/or as caregiver on behalf of the member named above (collectively, "you"), you authorize MedicAlert to release all medical and other confidential information about you in emergencies and to other healthcare personnel you designate. If you choose to terminate membership, you must notify us in writing. MedicAlert relies upon the accuracy of the information that you provide. You, therefore, agree to defend, indemnify, and hold MedicAlert (including its employees, officers, directors, agents, and organizations with which it maintains a marketing alliance for the provision of services hereunder) harmless from any claim or lawsuit brought by member or others for injury, death, loss or damages arising in whole or in part out of your provision of incomplete or inaccurate information to MedicAlert. Furthermore, as caregiver for the member named above, you hereby represent and warrant to MedicAlert that you have full power and authority, as the duly authorized representative of such member, to enroll and act on his or her behalf.

_____

Signature *Date (MM/DD/YYYY)*