RIVER FOREST TOWNSHIP

ICE PACKET
In Case of Emergency

FIRE RIVER FOREST DEPT.

MEDICAL INFORMATION FORM

PERSONAL INFORMATION:

Name _____ **Male** **Female**

Birth date _____ **Height** _____ **Weight** _____

Physician's Name & Phone # _____

IN CASE OF EMERGENCY, PLEASE CONTACT:

Contact #1: Name _____ Relationship _____

Address _____

Home Phone _____ Other Phone _____

Contact #2: Name _____ Relationship _____

Address _____

Home Phone _____ Other Phone _____

INSURANCE & DOCUMENTS:

Medicare? Yes No Medicare Claim No._____

Medicaid? Yes No Medicaid No. _____

Other Health Insurance Company: _____Group #_____

Policy #_____ Name of Insured: _____

Do you have:

DNR? Yes No (IF YES, PLEASE ATTACH A COPY OF DNR)

A Living Will? Yes No A Power of Attorney/Health Care Yes No

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CURRENT MEDICATIONS*

Name _____ Dosage _____

Name _____ Dosage _____

Name _____ Dosage _____

***FOR ADDITIONAL MEDICATIONS, PLEASE ATTACH LIST.**

Any allergies and/or reactions to medication? Yes No

Explain: _____

Pacemaker?	Yes	No	Glasses/Contacts?	Yes	No
Dentures?	Yes	No	Hearing Aids?	Yes	No
Artificial Limb?	Yes	No	Supplemental Oxygen?	Yes	No
Defibrillator?	Yes	No	Artificial Eye?	Yes	No

ARE YOU CURRENTLY OR HAVE YOU EVER BEEN TREATED FOR:

Heart Disease: Yes☐ No☐ Stroke: Yes☐ No☐ High Blood Pressure: Yes☐ No☐

Heart Attack: Yes☐ No☐ COPD: Yes☐ No☐ Asthma: Yes☐ No☐

Cancer: Yes☐ No☐ If yes, specify: _____ Diabetes: Yes☐ No☐

Depression/Other Mental Illness: Yes☐ No☐ Renal Disease: Yes☐ No☐

Other: _____

DISCLOSURE/DISCLAIMER STATEMENT: The information on this form is supplied by the resident or resident's representative who are solely responsible for its content. The ICE Packet is provided without cost as a courtesy to local residents. The River Forest Township and the River Forest Fire Department do not undertake any responsibility or obligations with respect to the accuracy of the information provided on or omitted from this form and shall not be held liable for any improper or incorrect use of the information contained herein. Additionally, River Forest Township is not responsible for any medical treatment received by the resident.

Resident's Signature: _____ **Date:** ____/____/____

PLEASE REMEMBER TO UPDATE THIS FORM AS YOUR MEDICATIONS AND/OR MEDICAL CONDITIONS CHANGE.