
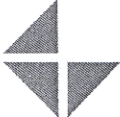


**Township of Downers Grove**  
**S.A.L.T. Council**  
(Seniors and Lawmen Together)  
*Serving and Protecting Senior Citizens*




This packet sponsored by the  
**Township of Downers Grove**  
**Human Services Division**

	Name: _____	Sex: M F
	Address: _____	

Doctor: \_\_\_\_\_ Phone #: \_\_\_\_\_

**EMERGENCY CONTACTS**

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_

Address: \_\_\_\_\_

*If you would like more information about the Downers Grove Township S.A.L.T. Council call 968-6408*

**MEDICAL DATA** as of: Mo. \_\_\_\_\_ Yr. \_\_\_\_\_ Blood Type: \_\_\_\_\_

Communicable Disease: \_\_\_\_\_

SEE BACK OF CARD FOR ADDITIONAL INFORMATION

Use pencil for ease in making changes.

Medical Problems	Medication	Dosage	Frequency

SEE BACK OF CARD FOR ADDITIONAL INFORMATION

Med Ins Co: \_\_\_\_\_ Policy #: \_\_\_\_\_

Other Med Ins Co: \_\_\_\_\_

Medicaid #: \_\_\_\_\_ Medicare #: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Religion: \_\_\_\_\_

**Special Conditions/Remarks:** \_\_\_\_\_

\_\_\_\_\_

SEE BACK OF CARD FOR ADDITIONAL INFORMATION

Health Care Proxy on file at \_\_\_\_\_

Living Will on file at \_\_\_\_\_

® FILE OF LIFE      Soc Sec # \_\_\_\_\_      Form: FOL MAC2

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Do you have an EMS-NO CPR Directive or a DNR Order?  
YES  NO  If yes, you need a DNR Bracelet.

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### MEDICAL CONDITIONS

*Check all that exist*

- |  |  |
|--|--|
| <input type="checkbox"/> No known medical conditions | <input type="checkbox"/> Hemolytic Anemia      |
| <input type="checkbox"/> Abnormal EKG                | <input type="checkbox"/> Hypertension          |
| <input type="checkbox"/> Adrenal Insufficiency       | <input type="checkbox"/> Hypoglycemia          |
| <input type="checkbox"/> Angina                      | <input type="checkbox"/> Laryngectomy          |
| <input type="checkbox"/> Asthma                      | <input type="checkbox"/> Leukemia              |
| <input type="checkbox"/> Bleeding Disorder           | <input type="checkbox"/> Lymphomas             |
| <input type="checkbox"/> Cardiac Dysrhythmia         | <input type="checkbox"/> Malignant Hypothermia |
| <input type="checkbox"/> Cataracts                   | <input type="checkbox"/> Memory Impaired       |
| <input type="checkbox"/> Clotting Disorder           | <input type="checkbox"/> Myasthenia Gravis     |
| <input type="checkbox"/> Coronary Bypass Graft       | <input type="checkbox"/> Pacemaker             |
| <input type="checkbox"/> Dementia( ) Alzheimer's( )  | <input type="checkbox"/> Renal Failure         |
| <input type="checkbox"/> Diabetes/Insulin Dependent  | <input type="checkbox"/> Seizure Disorder      |
| <input type="checkbox"/> Eye Surgery                 | <input type="checkbox"/> Sickle Cell Anemia    |
| <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Situs Inversus        |
| <input type="checkbox"/> Hearing Impaired            | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Heart Valve Prosthesis      | <input type="checkbox"/> Vision Impaired       |
| <input type="checkbox"/> Hemodialysis                | Other _____                                    |

### ALLERGIES

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Aspirin       | <input type="checkbox"/> Horse Serum   | <input type="checkbox"/> Sulfa              |
| <input type="checkbox"/> Barbiturites  | <input type="checkbox"/> Insect Stings | <input type="checkbox"/> Tetracycline       |
| <input type="checkbox"/> Codeine       | <input type="checkbox"/> Latex         | <input type="checkbox"/> X-Rays Dyes        |
| <input type="checkbox"/> Demerol       | <input type="checkbox"/> Lidocaine     | <input type="checkbox"/> No Known Allergies |
| <input type="checkbox"/> Environmental | <input type="checkbox"/> Morphine      | <input type="checkbox"/> Other _____        |
| _____                                  | <input type="checkbox"/> Novocaine     | _____                                       |
| _____                                  | <input type="checkbox"/> Penicillin    | _____                                       |

