

MEDICAL INSURANCE

None? Check here:

Medical insurance

Policy & Group #

Medical insurance

Policy & Group #

Medicare #

Medicaid #

HEALTH CARE PROVIDERS

Physician

Address

City / State / ZIP

Office phone

Physician

Address

City / State / ZIP

Office phone

NOTE: The Indiana Yellow Dot Motor Vehicle Medical Information Program acts as a facilitator only; all information supplied on the medical information form is the sole responsibility of the program participant. The program participant supplies this medical information voluntarily and authorizes the disclosure and use of the medical information for emergency purposes.

CURRENT MEDICATIONS

None? Check here:

Over-the-counter, vitamins and supplements

Prescription medication

Dosage

Times per day

Reason

Prescription medication

Dosage

Times per day

Reason

Prescription medication

Dosage

Times per day

Reason

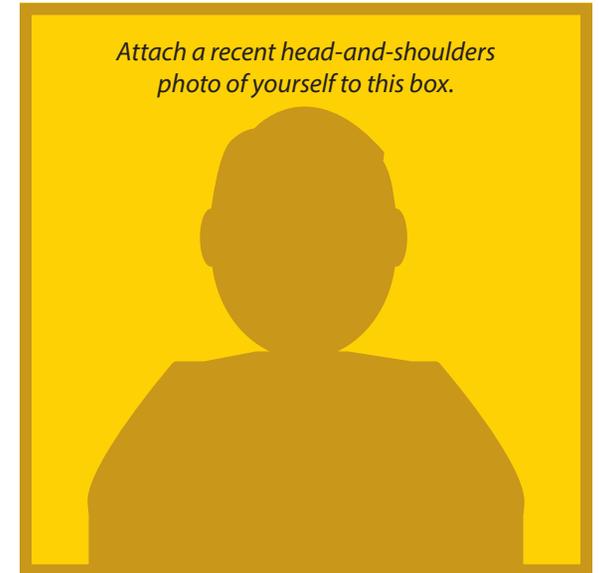
Instructions

1. Complete this form in pencil and print clearly.
2. Place this form inside the Yellow Dot envelope and place the envelope in the glove compartment of your motor vehicle or in the compartment attached to your motorcycle.
3. Affix the Yellow Dot decal on the left lower corner of the rear window of a motor vehicle or on a secure visible location on the rear of a motorcycle.
4. Update this form whenever your medical information or medications change.
5. New forms can be found at: www.in.gov/fssa/ddars/bba.

Yellow Dot Program

EMERGENCY MEDICAL INFORMATION

Attach a recent head-and-shoulders photo of yourself to this box.



Participant's name: _____

Date updated: _____



INDIANA ASSOCIATION
of AREA AGENCIES on AGING

KEEP YOUR INFORMATION CURRENT

Full name

Address

City / State / ZIP

Date of birth

Driver's license # (optional)

Religion/Spirituality (optional)

F M X Blood type

EMERGENCY CONTACTS

Name / relation

Address

City / State / ZIP

Home phone

Alternate phone

Name / relation

Address

City / State / ZIP

Home phone

Alternate phone

ADVANCE DIRECTIVES

Do you have an EMS-no CPR directive or DNR? Yes No

Do you have a POST order form? Yes No

My living will is on file at:

My health care surrogate is:

HOSPITAL PREFERENCE

(Transport to preferred hospital is *not* guaranteed.)

FUNERAL HOME PREFERENCE

RECENT SURGERIES

Surgeries in the last five years

Is my most recent EKG available? Yes No

It is located at:

ALLERGIES

(include drug, food, latex, etc.)

OTHER CONDITIONS

(chronic medical conditions, special needs, dementia, etc.)

ASSISTIVE DEVICES OR IMPLANTS

(e.g., pacemaker, oxygen, insulin pump, cochlear implant processor/hearing aids, spinal cord stimulators, chemotherapy pumps or similar devices)

ADDITIONAL NOTES

(for first responders)

Check all that apply:

- Contact lenses Pacemaker
 Dentures Metal in body