

1. Complete this information kit completely and legibly. (Get assistance if required.)
2. When complete, place in plastic envelope provided.
3. Attach pouch on the top shelf of your refrigerator on the right-hand side.
4. Place one "LIFE Kit" decal on the outside of the refrigerator and the other "LIFE Kit" decal on the main entrance into your house.
5. If you have a LIVING WILL or DNR please fill out last line on next page. PROVIDE ORIGINAL OF DOCUMENT SIGNATURE CANNOT BE A PHOTOCOPY

KEEP THIS INFORMATION UP TO DATE

Date Filled in (YYYY-MM-DD)		Date Updated (YYYY-MM-DD)	
First Name	Middle Name	Last Name	
Gender	Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single <input type="checkbox"/> Widow(er)		
Address (Street Number)		Apartment	
City/Town		Province	Postal Code
Telephone Number		Birth Date (YYYY-MM-DD)	
Height	Weight	Hair Color	
Provincial Care Card Number	Extended Health Care Provider	Extended Health Care Number	
Do you wear medical alert <input type="checkbox"/> Yes <input type="checkbox"/> No	Mobility: Do you use any of the below <input type="checkbox"/> Cane <input type="checkbox"/> Wheelchair <input type="checkbox"/> Power Wheelchair <input type="checkbox"/> Scooter <input type="checkbox"/> Other		

IN CASE OF EMERGENCY PLEASE NOTIFY

Name*CONTACT PERSON FOR LIVING WILL OR DNR* IF YOU HAVE ONE		
Telephone Number	Relationship	
Name		
Telephone Number	Relationship	
Family Doctors and/or Specialists Name		
Do you speak English? <input type="checkbox"/> Yes <input type="checkbox"/> No	If not Mother Tongue?	Pharmacy
Do you wear Contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you wear Dentures? <input type="checkbox"/> Yes <input type="checkbox"/> No	Blood type (if known)
*DO YOU USE BLOOD THINNERS? <input type="checkbox"/> Yes <input type="checkbox"/> No		

Existing Conditions		
<input type="checkbox"/> Aids	<input type="checkbox"/> COPD	<input type="checkbox"/> Hearing Problems <input type="checkbox"/> Lung Trouble
<input type="checkbox"/> Alzheimer's/Dementia	<input type="checkbox"/> Diabetes (Type 1)	<input type="checkbox"/> Heart Conditions <input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes (Type 2)	<input type="checkbox"/> Hepatitis <input type="checkbox"/> Stomach/Bowel <input type="checkbox"/> Liver Disease
<input type="checkbox"/> Blood Pressure (High)	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease <input type="checkbox"/> Urinary tract
<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma infections	

