Project ICE

In Case of Emergency

Provided By:

Cherokee County Public Health

Provided by Cherokee Regional

Personal Information:

Name: _____

Date of Birth: _____

Age: _____ Gender: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Insurance: _____

Policy: _____

Insurance: _____

Policy: _____

Emergency Contacts:

Contact One

Name: _____

Relation: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Contact Two

Name: _____

Relation: _____

Address: _____

_____

Home Phone: _____

Cell Phone: _____

Medical Information:

Current Medical Diagnoses: _____

_____

_____

_____

Preferred Hospital: _____

Provider: _____

Phone Number: _____

Pharmacy: _____

Phone Number: _____

Allergies: _____

_____

_____

Blood Type: ☐A+ ☐A- ☐B+ ☐B- ☐O+ ☐O- ☐AB+ ☐AB-

Check All That Apply to You:

- ☐ Portable Oxygen
- ☐ CPAP
- ☐ BIPAP
- ☐ Walker
- ☐ Wheelchair
- ☐ Cane
- ☐ Prosthesis
- ☐ Glasses
- ☐ Hearing Aids
- ☐ Dentures
- ☐ Insulin
- ☐ Insulin Pump
- ☐ Diabetic Monitoring Devices
- ☐ Pacemaker
- ☐ Cardiac Monitor
- ☐ Guide Cane
- ☐ Cochlear Implant
- ☐ Communicaton Devices
- ☐ Service Animal
- ☐ Feeding Tube
- ☐ Ostomy
- ☐ Other: _____

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Cherokee, IA 51012

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cherokeermc.org

Please Also Enclose:

- Your updated medication list after each visit with your provider
- Your provider-signed IPOST document