

# Member enrollment



3772 NORTH BOULEVARD  
BATON ROUGE, LA 70806  
(225) 334-7494

Last name \_\_\_\_\_  
 First name \_\_\_\_\_  
 Nickname \_\_\_\_\_  
 Address (no PO Boxes) \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ ZIP code \_\_\_\_\_  
 Phone (\_\_\_\_\_) \_\_\_\_\_  
 Birth date \_\_\_\_\_  Male  Female  
 Last 4 digits of Social Security No. \_\_\_\_\_  
 Height \_\_\_\_\_ Weight \_\_\_\_\_  
 Eye color \_\_\_\_\_ Hair color \_\_\_\_\_  
 Race/ethnicity \_\_\_\_\_  
 Skin tone  Dark  Medium  Fair  
 Mole  Tattoo  Scar  Birth mark

### Drug allergies

List all known drug allergies

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Medications

List all medications and dosages, including inhalers

Medication	Prescribed Dosage

### Medical conditions

Only individuals with Alzheimer's or a related dementia are eligible for the MedicalAlert + Safe Return program.

- Alzheimer's Disease  
 Other Dementia

### Other conditions

- |   |   |
|---|---|
| <input type="checkbox"/> Angina                                       | <input type="checkbox"/> Epilepsy                 |
| <input type="checkbox"/> Arthritis                                    | <input type="checkbox"/> Glaucoma                 |
| <input type="checkbox"/> Asthma                                       | <input type="checkbox"/> Hearing Impaired         |
| <input type="checkbox"/> Atrial Fibrillation                          | <input type="checkbox"/> Hypertension             |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) | <input type="checkbox"/> Myocardial Infarction    |
| <input type="checkbox"/> Congestive Heart Failure                     | <input type="checkbox"/> Organ Transplant         |
| <input type="checkbox"/> Coronary Artery Disease                      | <input type="checkbox"/> Seizure Disorder         |
| <input type="checkbox"/> Diabetes                                     | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Emphysema                                    | <input type="checkbox"/> Von Willebrand's Disease |
- Other \_\_\_\_\_  
 Implant\* \_\_\_\_\_

### Primary contact information

Last name \_\_\_\_\_  
 First name \_\_\_\_\_  
 Address (no PO Boxes) \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ ZIP code \_\_\_\_\_  
 Phone home (\_\_\_\_\_) \_\_\_\_\_  
 cell (\_\_\_\_\_) \_\_\_\_\_  
 work (\_\_\_\_\_) \_\_\_\_\_  
 Email \_\_\_\_\_

### Secondary contact information

Last name \_\_\_\_\_  
 First name \_\_\_\_\_  
 Address (no PO Boxes) \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ ZIP code \_\_\_\_\_  
 Phone home (\_\_\_\_\_) \_\_\_\_\_  
 cell (\_\_\_\_\_) \_\_\_\_\_  
 work (\_\_\_\_\_) \_\_\_\_\_  
 Email \_\_\_\_\_

Optional \$25 caregiver enrollment

Last name \_\_\_\_\_  
 First name \_\_\_\_\_  
 Nickname \_\_\_\_\_  
 Address (no PO Boxes) \_\_\_\_\_  
 City \_\_\_\_\_  
 State \_\_\_\_\_ ZIP code \_\_\_\_\_  
 Phone home (\_\_\_\_\_) \_\_\_\_\_  
 cell (\_\_\_\_\_) \_\_\_\_\_  
 work (\_\_\_\_\_) \_\_\_\_\_  
 Birth date \_\_\_\_\_  Male  Female  
 Last 4 digits of Social Security No. \_\_\_\_\_

### Drug allergies

List all known drug allergies

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Medications

List all medications and dosages, including inhalers

Medication	Prescribed Dosage

### Medical conditions

Check the box next to each of your conditions and write in any others. While these conditions are very important, any condition that requires continued physician care or special attention in an emergency should be noted.

- |   |   |
|---|---|
| <input type="checkbox"/> Angina                                       | <input type="checkbox"/> Epilepsy                 |
| <input type="checkbox"/> Arthritis                                    | <input type="checkbox"/> Glaucoma                 |
| <input type="checkbox"/> Asthma                                       | <input type="checkbox"/> Hearing Impaired         |
| <input type="checkbox"/> Atrial Fibrillation                          | <input type="checkbox"/> Hypertension             |
| <input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD) | <input type="checkbox"/> Myocardial Infarction    |
| <input type="checkbox"/> Congestive Heart Failure                     | <input type="checkbox"/> Organ Transplant         |
| <input type="checkbox"/> Coronary Artery Disease                      | <input type="checkbox"/> Seizure Disorder         |
| <input type="checkbox"/> Diabetes                                     | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Emphysema                                    | <input type="checkbox"/> Von Willebrand's Disease |
- Other \_\_\_\_\_  
 Implant\* \_\_\_\_\_  
 No known medical conditions

### Emergency contact

Last name \_\_\_\_\_  
 First name \_\_\_\_\_  
 Nickname \_\_\_\_\_  
 Phone home (\_\_\_\_\_) \_\_\_\_\_  
 cell (\_\_\_\_\_) \_\_\_\_\_  
 work (\_\_\_\_\_) \_\_\_\_\_

\* Please list the manufacturer model and serial number, or include a copy of your implant card with this form.

## Member ID jewelry & payment

### Select your ID jewelry included in your membership

Products are shipped to the primary caregiver unless otherwise requested.

#### Measure wrist for ID bracelet

Use a flexible tape measure to determine wrist size, or wrap a string around your wrist and measure it against the ruler on the side of this page.

#### Front of jewelry

- Z101 Stainless Steel Large Emblem, Purple Logo w/ Bracelet (not pictured)
- Z102 Stainless Steel Small Emblem, Purple Logo w/ Bracelet



- Z100 Stainless Steel Round Pendant, Purple Logo



#### Back of jewelry



Other products are available online at [www.medicalert.org/safereturn](http://www.medicalert.org/safereturn)

#### Emblem engraving

In an emergency, response personnel need to be aware of your loved one's critical medical information in order to treat them correctly. Their MedicalAlert + Safe Return jewelry will be engraved with their member ID number and our 24-hour emergency response number to enable responders to assist your loved one immediately. To help assure you receive thorough, accurate treatment, the condition our trained staff deems most relevant to your medical needs in an immediate emergency treatment will be engraved on the jewelry.

**Please note:** Once your jewelry has been engraved and shipped, there will be an additional charge for any changes requested. Jewelry engraving is personalized to individual members and cannot be transferred to another individual, altered, sold or returned.

### Member jewelry selection

- Type  Small Stainless Steel bracelet (1<sup>3</sup>/<sub>8</sub>" )  
 Large Stainless Steel bracelet (1<sup>5</sup>/<sub>8</sub>" )  
 Stainless Steel pendant (1<sup>1</sup>/<sub>4</sub>" ) with necklace (26" chain)

Exact wrist measurement \_\_\_\_\_ inches  
*(Required for bracelet. Please measure wrist snugly and add 1/2".)*

### Caregiver jewelry selection (if purchasing caregiver membership)

- Type  Small Stainless Steel bracelet (1<sup>3</sup>/<sub>8</sub>" )  
 Large Stainless Steel bracelet (1<sup>5</sup>/<sub>8</sub>" )  
 Stainless Steel pendant (1<sup>1</sup>/<sub>4</sub>" ) with necklace (26" chain)

Exact wrist measurement \_\_\_\_\_ inches  
*(Required for bracelet. Please measure wrist snugly and add 1/2".)*

#### Consent

**Important:** By accepting membership in MedicalAlert Foundation, for yourself as member or caregiver and/or as caregiver on behalf of the member named above (collectively, "you"), you authorize MedicalAlert to release all medical and other confidential information about you in emergencies and to other health care personnel you designate. If you choose to terminate membership, you must notify us in writing and return your jewelry. MedicalAlert relies upon the accuracy of the information that you provide. You, therefore, agree to defend, indemnify, and hold MedicalAlert (including its employees, officers, directors, agents, and organizations with which it maintains a marketing alliance for the provision of services hereunder) harmless from any claim or lawsuit brought by member or others for injury, death, loss or damages arising in whole or in part out of your provision of incomplete or inaccurate information to MedicalAlert. Furthermore, as caregiver for the member named above, you hereby represent and warrant to MedicalAlert that you have full power and authority, as the duly authorized representative of such member, to enroll and act on his or her behalf.

#### Signature

### Recent photo of member provided?

- Yes  No

*Send original photo, passport size or larger. Photo will not be returned. Please write member's name on back of photo.*

### Cost

One time enrollment fee	<b>\$ 49.95</b>
Optional caregiver membership and jewelry (\$25.00)	_____
Shipping and handling	<b>\$ 4.95</b>
<b>Total</b>	<b>\$ _____</b>

### \$25 annual renewal fee

When annual fee is due, I authorize the \$25 charge to my designated account listed below:

- Yes  No

### Payment

- Check *(made payable to MedicalAlert Foundation)*  
 Visa®  Mastercard®  
 American Express®  Discover®

Card number \_\_\_\_\_

Expiration date \_\_\_\_ / \_\_\_\_

Cardholder's name: \_\_\_\_\_

Cardholder's signature: \_\_\_\_\_