County of Essex

"Cool Aid" Program

First Name: ______________________ Last Name: ______________________

Address: ____________________________________ Phone #: ____________

Health Card #: ______________________________ Date of Birth: ___ / ___ / ___
mm / dd / yy

Family Doctor: ______________________________ Phone #: ____________

Substitute Decision Maker: ____________________ Phone #: ____________

DNRC Form Attached? ☐ Yes ☐ No DNRC #

Advanced Care Plan? ☐ Yes ☐ No

This individual tends to walk away / go missing ☐ Yes ☐ No [If YES, attach photo to back of form]

Medical History: (place a check mark beside all that apply)

☐ Heart Attack (last) ____________	☐ Stroke	☐ Emphysema
☐ High Blood Pressure	☐ Angina	☐ Seizures
☐ Congestive Heart Failure	☐ Diabetes	☐ Bleeding Ulcers
☐ Asthma	☐ Pace Maker	☐ Osteoporosis
☐ Implanted Defibrillator	☐ Bronchitis	☐ COPD
☐ On Home Oxygen		
☐ Other (please specify) ____________________		

Current Medication and Dosage: (prescribed)

Write in or attach a current list of your medications from your pharmacy. Please update if medications change.

____
____
____
____
____
____

Allergies That You Have (include reaction if exposed ie – rash, hives, etc):

____
____
____

Once you have completed recording your medical history, place this report on the FRONT OF YOUR REFRIGERATOR.

PARAMEDICS NEED THIS INFORMATION IF YOU ARE UNABLE TO COMMUNICATE AT THE TIME OF THE EMERGENCY

To request "Cool Aid" medical information forms please email our office at dfortier@countyofessex.on.ca

Or call 519-776-6441 ext. 2232