OFFER CODE:___________

MEDICALERT REGISTRATION SHEET

REGISTRANT INFORMATION			
NAME:			
STREET ADDRESS and CITY:			
POSTAL CODE:		EMAIL ADDRESS:	
PHONE NUMBER:		ALTERNATE NUMBER:	
DATE OF BIRTH:		PRODUCT CODE and WRIST SIZE:	
EMERGENCY CONTACT INFORMATION			
NAME:		NAME:	
PHONE NUMBER:		PHONE NUMBER:	
ALTERNATE NUMBER:		ALTERNATE NUMBER:	
RELATIONSHIP:		RELATIONSHIP:	
PHYSICIAN INFORMATION			
NAME:			
PHONE NUMBER:			
SPECIALTY:			
MEDICAL INFORMATION			
☐ ALZHEIMERS	☐ OTHER DEMENTIAS (Please specify):		
☐ AUTISM	☐ NON-VERBAL	☐ BRAIN INJURY	☐ MENTAL HEALTH ISSUES
OTHER MEDICAL CONDITIONS / SPECIAL NEEDS (Please specify):			
PRESCRIPTION MEDICATIONS: (Dosages not required)			
SECTION BELOW IS IMPORTANT TO COMPLETE IF PERSON HAS A TENDENCY TO WANDER OR GO MISSING			
LIVING ARRANGEMENT:	Height:	Hair color:	
☐ ALONE	Weight:	Eye color:	
☐ WITH FAMILY	Race:	Visible Marks:	
☐ IN A FACILITY	Skin complexion:	Language spoken:	
WANDERING HISTORY:	☐ NEVER	☐ I-4 TIMES	☐ MORE THAN 4 TIMES
POSSIBLE LOCATIONS IF WANDERS:			
DE-ESCALATION TECHNIQUES DURING CRISIS:			
TRIGGERS/STRESSORS:			

EMAIL: CONNECTPROTECT@MEDICALERT.CA // FAX: 1800.392.8422 // CALL: 1.866.696.0273