

Please fill out this form on behalf of the member.

For assistance call us at 1-855-581-3794 (toll free, Mon-Fri 9am-5pm EST).

MEMBER'S PERSONAL INFORMATION

Mr. Mrs. Ms. Dr. First Name _____ Last Name _____

Name to be engraved on I.D. _____ Gender: M F Date of Birth (m/d/y) ____/____/____

Language Spoken: English French Other _____

Is the member a veteran currently receiving benefits from Veteran Affairs Canada (VAC)? Yes No
 (If **Yes**, please indicate the member's VAC Health ID # below and **do not** enclose payment. We will confirm with Veterans Affairs Canada if the member is eligible for this service and we'll contact you if needed)

VAC Health Identification Number K ____ _ ____ _ ____ _ ____ _

MEMBER'S LIVING ARRANGEMENT

Alone With family Facility _____ Other _____

Address _____ Apt. _____ City _____ Province/Territory _____ Postal Code _____

Main No. _____ Bus No. _____ Ext. _____ Cell No. _____

DESCRIPTION OF MEMBER

Height: ____ ft ____ in or ____ cm Weight: ____ lbs or ____ kg Hair colour _____ Eye colour _____

Race: Aboriginal Arab/West Asian Black Caucasian Chinese Filipino Japanese
 Korean Latin American Mixed South Asian Other _____ Unknown

Skin complexion: Dark Olive Light/Fair Ruddy Sallow Other _____

Visible marks: Scars Marks Moles Tattoos Freckles Deformities Pimples/pockmarked

Description / location of visible marks: _____

WANDERING HISTORY

How many times has the member wandered in the past? Never 1-4 times Over 4 times

Please specify possible places where this person may wander to (eg. former living addresses or places of employment, favourite stores, post office, etc.): _____

CAREGIVER INFORMATION (MAIN CONTACT)

Name _____ Relationship _____

Address _____ Apt. _____ City _____ Province/Territory _____ Postal Code _____

Main No. _____ Best time to call _____ Bus No. _____ Ext. _____ Cell No. _____

Email _____ Language: English French

Please check this box to indicate that, as the caregiver, you have the permission of the member or a legal right to receive all correspondence on their behalf, unless otherwise stated.

MEDICAL CONDITIONS (RECOGNIZED MEDICAL TERMINOLOGY AND ABBREVIATIONS WILL BE USED)

Engraving language: English French

Medical conditions (include any major surgeries or medical procedures):

All current prescription medications:

Allergies/anaphylaxis:

Do you use an epinephrine injector? Yes No

Implants/devices (include a copy of your implant card if possible):

Type _____ Manufacturer _____

Model No. _____ Serial No. _____

Special needs _____

EMERGENCY MEDICAL CONTACTS

Physician 1 _____ Specialty _____

Bus. No. _____ ext. _____

Physician 2 _____ Specialty _____

Bus. No. _____ ext. _____

OTHER PERSONAL EMERGENCY CONTACTS

1. Name _____ Relationship _____

Address _____ Apt. _____ City _____ Province/Territory _____ Postal Code _____

Main No. _____ Best time to call _____ Bus No. _____ Ext. _____ Cell No. _____

Email _____ Language: English French

2. Name _____ Relationship _____

Address _____ Apt. _____ City _____ Province/Territory _____ Postal Code _____

Main No. _____ Best time to call _____ Bus No. _____ Ext. _____ Cell No. _____

Email _____ Language: English French

CHOOSE THE STYLE



Stainless Steel Blue ID #157



Designer Stainless Steel Blue ID #158

CHOOSE WRIST SIZE

5"
 5 1/2" 6 1/2" 7 1/2"
 6" 7" 8"

For only \$60* receive 1-year of MedicAlert protection plus a free MedicAlert Stainless Steel 'Blue' ID.
 *Price includes applicable taxes and s&h

METHOD OF PAYMENT

Cheque Please make your \$60 cheque payable to: **Canadian MedicAlert Foundation, 2005 Sheppard Ave. East, Suite 800, Toronto, ON M2J 5B4**

VISA Credit card # _____ / _____ / _____ Expiry Date (m/y) ____ / ____

MasterCard

American Express Name as it appears on card: _____ Signature: _____

READ & SIGN THE PRIVACY AGREEMENT BELOW.

Consent: By becoming a member, purchasing and wearing any emblem or product identifying you as a MedicAlert[®] member, you will be agreeing to the arrangement summarized below and described in the MedicAlert Member Statement that you may obtain on our website (MedicAlert.ca) or by calling (1-800-668-1507). **YOU MUST READ THE MEMBER STATEMENT BEFORE APPLYING FOR MEDICALERT MEMBERSHIP BECAUSE IT DESCRIBES THE CHOICES YOU HAVE ABOUT MEDICALERT PROGRAMS AND SERVICES, THE INFORMATION YOU RECEIVE FROM US (see below as well), AND OTHER IMPORTANT MATTERS AFFECTING YOUR PRIVACY AND SAFETY.** Please call us if you would like an explanation or to discuss anything in the Member Statement.

When you become a member, MedicAlert will create an electronic file under your name, which will be kept at MedicAlert in Toronto, and will hold all of the information about you and your health that we receive from you and/or others. MedicAlert will provide you with a customized MedicAlert ID, its 24-hr hotline (emergency) service, and information. **MedicAlert will disclose information in your file to emergency personnel and others, including MedicAlert operators in the U.S.A., to provide you with the**

hotline service. MedicAlert may share and receive personal information about you at any time from anyone you name as a contact, unless you specify otherwise.

If you participate in the MedicAlert[®] Safely Home[®] Program, MedicAlert will also provide some of the information in your file to the Alzheimer Society of Canada and the local Alzheimer Society chapter for the purposes of offering access to support and education. You will also receive information about how the work of the Alzheimer Society in Canada is funded, unless you decline below.

You may review your file online or by calling us. You are responsible for making sure that the information in your file is correct. MedicAlert will not be responsible for any harm caused because the information in your file is incomplete or inaccurate. You will be required to pay member fees. You or MedicAlert may cancel your membership by following the MedicAlert Cancellation Process - **You will not receive any MedicAlert services and will be required to stop wearing your MedicAlert ID as soon as you stop being a member.**

You ACKNOWLEDGE and agree that you have read and understand the MedicAlert Member Statement available online at MedicAlert.ca and by calling 1-800-668-1507. If you are not the applicant, you represent that you have the permission of the applicant or a legal right to complete this form on behalf of the applicant.

You will receive special promotions, and information on third party (partner) programs that may be of interest to you, unless you decline below.

Signature: _____ Date: _____

Name: (print) _____ Phone Number: _____

Relationship to member: _____

Communication	Method			
	E	M	T	D
Email (E); Mail (M); Mobile/Text (T); Do Not Send (D)				
All communications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Newsletters & member stories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MedicAlert Foundation product news	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MedicAlert Foundation offers & promotions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3rd Party partner offers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Information about Charitable Work				
• MedicAlert Foundation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
• Alzheimer Society	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>