Kaleidoscope Cottage
"First Aid Kit"

Cottager Name: _____ Birth Date:_____
Address:_____ City:_____
OHIP number:_____
Emergency Contact:_____ Relationship:_____
Contact number(s): _____
Primary physician:_____ Phone number:_____

Please list all that apply:
Contact Lenses____ Glasses____Dentures____ Upper____Lower____Pacemaker____
Cane____Walker____Metal in body____Diabetic____Seizures____Smoker____

Please list all allergies:_____
_____

Dietary Restrictions:_____

Current medical conditions:_____
_____
_____

Relevant surgeries and hospitalizations:

Year	Surgery Performed/Reason for Hospitalization

Is there a Do Not Resuscitate Order? Yes____ No____
Advanced Directives?_____
_____
Document Location:_____
Is there a Power of Attorney? Yes____ No____
Name: _____ Relationship:_____ Contact number:_____

Form completed by:_____ Relationship:_____

Signature:_____ Date:_____