

Member enrollment 入會申請表

Last name 姓 _____

First name 名 _____

Nickname 暱稱 (別名) _____

Address (no PO Boxes) 住址 (不能用郵政信箱號碼)

City 市 _____

State 州 _____ ZIP code 郵遞區號 _____

Phone 電話 () _____

Birth date 生日 _____ Male 男 Female 女

Last 4 digits of Social Security No.

社會安全號碼最後四個數字 _____

Height 身高 _____ Weight 體重 _____

Eye color 眼睛顏色 _____

Hair color 頭髮顏色 _____

Race/ethnicity 種族 _____

Skin tone 皮膚顏色 Dark 深 Medium 中等 Fair 淺

Mole 痣 Tattoo 刺青 Scar 疤痕 Birth mark 胎記

Drug allergies 過敏藥物

List all known drug allergies 請列出所有的過敏藥物

Medications 日常用藥

List all medications and dosages, including inhalers
請列出所有的藥物名稱與劑量, 包括吸入劑

Medication 藥物名稱	Prescribed Dosage 劑量
_____	_____
_____	_____
_____	_____
_____	_____

Medical conditions 健康狀況

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

只有阿滋海默症患者或與失智症相關的病人可以申請醫療警覺暨安全返家計畫

Alzheimer's disease 阿滋海默症

Other dementia 其他失智症 _____

Other conditions 其他病史

Angina 心絞痛

Arthritis 關節炎

Asthma 氣喘

Atrial Fibrillation

心房纖維顫動

Hypertension 高血壓

Myocardial Infarction

心肌梗塞

Congestive Heart Failure

充血性心衰竭

Coronary Artery Disease

冠狀動脈疾病

Diabetes 糖尿病

Emphysema 肺氣腫

Epilepsy 癲癇

Glaucoma 青光眼

Hearing Impaired

聽力減退

Chronic Obstructive

Pulmonary Disease (COPD)

慢性阻塞性肺部疾病

Organ Transplant

器官移植

Seizure Disorder

抽搐病變

Stroke 中風

Von Willebrand's Disease

溫韋柏氏疾病

Other 其他 _____

Implant* 植入物 _____

Primary contact information 第一聯絡人資料

Last name 姓 _____

First name 名 _____

Address (no PO Boxes) 住址 (不能用郵政信箱號碼)

City 市 _____

State 州 _____ ZIP code 郵遞區號 _____

Phone home 電話--家 () _____

Cell 行動電話 () _____

Work 電話--工作 () _____

Email 電子郵件 _____

Secondary contact information 第二聯絡人資料

Last name 姓 _____

First name 名 _____

Address (no PO Boxes) 住址 (不能用郵政信箱號碼)

City 市 _____

State 州 _____ ZIP code 郵遞區號 _____

Phone home 電話--家 () _____

Cell 行動電話 () _____

Work 電話--工作 () _____

Email 電子郵件 _____

Optional \$35 caregiver enrollment

照顧者可選擇另加付費\$35也成為會員

Last name 姓 _____

First name 名 _____

Address (no PO Boxes) 住址 (不能用郵政信箱號碼)

City 市 _____

State 州 _____ ZIP code 郵遞區號 _____

Phone home 電話--家 () _____

Cell 行動電話 () _____

Work 電話--工作 () _____

Email 電子郵件 _____

Birth date 生日 _____ Male 男 Female 女

Last 4 digits of Social Security No.

社會安全號碼最後四個數字 _____

* Please list the manufacturer model and serial number, or include a copy of your implant card with this form.
請列出製造廠商之名稱以及製造型及編號, 或隨本申請表附上植入物卡的影本。

Member ID jewelry & payment 會員識別牌及付款方式

1"

Select your ID jewelry included in your membership 選擇您的識別首飾

Products are shipped to the primary caregiver unless otherwise requested.
加入會員, 可以選識別手鍊或項鍊(二選一)- 除非特別要求,
識別牌會郵寄至照顧者地址.

2"

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.
若選擇識別手鍊, 請量手腕尺寸.

以軟尺量手腕尺寸或用線繞手腕一圈,

再以此繞手腕一圈長度的線對齊本紙左方之尺, 即為手腕尺寸.

3"

Front of jewelry 識別首飾正面

- Z101 Stainless steel large emblem, purple logo w/ bracelet (not pictured)
不銹鋼製紫色標誌(大)暨手鍊(無照片)
- Z102 Stainless steel small emblem, purple logo w/ bracelet
不銹鋼製紫色標誌(小)暨手鍊(如圖示)



5"

- Z100 Stainless steel round pendant, purple logo
不銹鋼製圓形項鍊識別牌紫色標誌
(如圖示)



6"

Back of jewelry 識別首飾反面(如圖示)



7"

8"

Member jewelry selection 會員識別牌的選擇

- Type Small stainless steel bracelet (1³/₈")
不銹鋼識別(小號1又3/8吋)手鍊
- Large stainless steel bracelet (1⁵/₈")
不銹鋼識別(大號1又5/8吋)手鍊
- Stainless steel pendant (1¹/₄") with
necklace (26" chain) 不銹鋼製圓形項鍊
識別牌(1又1/4吋)並附26吋項鍊

Exact wrist measurement _____ inches
(Required for bracelet. Please measure wrist snugly
and add 1/2".) 手腕尺寸_____吋(以前述方法
量出手腕尺寸, 再加1/2吋).

Consent 同意書

Important: By accepting membership in MedicAlert Foundation, for yourself as member or caregiver and/or as caregiver on behalf of the member named above (collectively, "you"), you authorize MedicAlert 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. MedicAlert relies upon the accuracy of the information that you provide. You, therefore, agree to defend, indemnify, and hold MedicAlert (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 MedicAlert. Furthermore, as caregiver for the member named above, you hereby represent and warrant to MedicAlert that you have full power and authority, as the duly authorized representative of such member, to enroll and act on his or her behalf.

你自己或身為患者之照顧者,
和/或你身為患者之照顧者代表患者以前述之姓名
加入為會員(統稱為你),來接受醫療警覺安全機構
會員的身份. 你授權醫療警覺安全機構, 在緊急情
況時,讓你所指定的醫護人員獲得該會員全部醫療
狀況及其他保密資料.

如果你決定終止會員的身份, 你必須以書面通知本
機構, 並且退回你所擁有的會員手鍊或項鍊識別牌.
本機構仰賴你提供準確詳盡的資料, 因此若由於你
提供的資料不完全或不確實而導致該會員, 或他人
受到損失, 傷害或死亡, 你不得對本醫療警覺安全
機構及員工, 職員和其連線機構提出訴訟或要求賠
償. 除此之外, 身為前述之姓名加入為會員之照顧
者, 你為該會員之法定全權代理人,
代表他/她參與醫療警覺安全機構.

Signature 簽名

Recent photo of member provided? 會員之近照?

Yes 有 No 無

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

需要護照尺寸(或更大)照片一張.請在該照片
背面註明姓名. 此照片不退回.

Cost 收費

One time enrollment fee 加入為會員	\$ 55
Shipping and handling 手續費, 郵寄費	\$ 7

Total 總額 \$ _____

\$35 annual renewal fee 每年會員收費

When annual fee is due, I authorize the \$35 charge to
my designated account listed below:

我授權以下列付款方式, 支付每年會員會費:

Yes 有 No 無

Payment 付款方式

Check 支票 (made payable to MedicAlert Foundation;
受款者為 MedicAlert Foundation)

Visa® Mastercard®

American Express® Discover®

Card number 信用卡號碼

Expiration date 有效日期 _____ / _____

Cardholder's name 持卡者姓名:

Cardholder's signature 持卡者簽名:
