

Please fill out this form in pencil and keep it with the Advance Directives, Family Emergency Plan, and Public Health Preparedness information.

Update information whenever changes occur.

Important Numbers

Emergency.....	911
Poison Control.....	1-800-222-1222
	1-800-942-5969
TTY/TDD.....	1-312-906-6185
Ambulance.....	911
Abraham Lincoln Memorial Hospital.....	1-217-732-2161
Substance Abuse	
AA.....	1-800-274-2042
Logan Mason.....	1-217-735-2272
Domestic Violence.....	1-866-435-7438
Suicide Intervention.....	1-217-732-3600
Public Health Info. On Human Services Resources (LCHD).....	1-217-735-2317
Emergency Services	
Disaster Agency.....	1-217-732-9491
Legal Assistance Foundation, Inc.....	1-800-252-8629
	1-217-753-3300

Made possible through the Logan County Health Department.

Logan County Health Department
109 Third Street
Lincoln, Ill. 62656
217-735-2317

lchd@logancountyhealth.org
www.logancountyhealth.org

Funded in part through a Homeland Security grant.

Book of Life

Contains Vital Medical Information

Provided by:

Logan County Health Department

109 Third Street
Lincoln, IL 62656
217-735-2317

lchd@logancountyhealth.org

www.logancountyhealth.org

Name _____

Address _____

Date of Birth _____ Male Female

SS # _____ Married Yes NO

Doctor _____ Phone _____

Emergency Contacts

Name _____ Phone _____

Address _____

Name _____ Phone _____

Address _____

Pastor _____ Phone _____

(Use pencil for ease in making changes)

Medical Conditions

<input type="checkbox"/> Heart/Angina	<input type="checkbox"/> Stroke
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Renal Failure
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer
<input type="checkbox"/> Lung Problem	<input type="checkbox"/> Asthma
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypoglycemia
<input type="checkbox"/> Seizure Disorder	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Other	

Recent Surgeries _____

Communicable Diseases _____

Allergies _____

Medication	Dose	Frequency

I have the following physical limitations.

- I wear glasses
- I use a cane/walker
- I wear a hearing aid Right Ear Left Ear
- Health Care Proxy on file Yes No
- Living Will on file Yes No

Med. Ins. Co. _____ Policy # _____

Secondary Ins. _____ Policy # _____

Medicare # _____ Medicaid # _____

Date of Birth _____ Religion _____

Hospital Preferred _____