Place current photo here

Emergency Medical Information

Complete this form for each member of your family. Keep in Family Disaster Plan notebook with any other vital medical information.

Name_____

Address_____

_____

Telephone# (day)_____ (evening)_____

Birthdate_____

Allergies_____

Physician's Name_____

Address_____

_____

Telephone#_____

Pharmacy_____

Address_____

_____

Telephone#_____

Immunization Record

	DTP/DT		
1	Month	Day	Year
2			
3			
4			
5			
6			
	Polio		
1			
2			
3			
4			
5			
	MMR		
1			
2			
3			
	Hepatitis B		
1			
2			
3			
	Hib		
1			
2			
3			
4			

Emergency Medical Information

continued

Medications

List all prescription and over the counter drugs you take, including the dosage.

Medical History

Check if you have a **family** history of

- ☐ Heart Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Bleeding Disorders

Past Medical History

Circle if you have ever had any of the following:

Anemia	Heart Attack
Jaundice	Stroke
Peptic Ulcer	Thyroid Disease
Hepatitis	Kidney Disease
Diabetes	Emphysema
Pneumonia	High Blood Pressure
Blood Clots	Excessive Bleeding
Angina	Congestive Heart Failure
Cancer	Shortness of Breath
Tuberculosis	Abnormal Hearth Rhythm

Hospitalizations and Surgery

(List all hospitalizations and surgeries you've had)

Immunization Record

continued

	Td		
	Month	Day	Year
1			
2			
3			
4			
5			
6			
7			
8			

Other

Type	Month	Day	Year

Allergies

(List any drugs you are allergic to):