Keep It With You

PERSONAL MEDICAL INFORMATION FORM

NAME:___________________________________
Date of Birth: ___/___/_____
Male____ Female____
E-mail:___________________________________

Home Address:____________________________
____
City:_____________________________________
State:____ Zip:____________
Phone Number:____________________________

Temporary Address:_______________________
____
City:_____________________________________
State:_____ Zip:____________
Phone Number:____________________________

Previous evacuee center location(s):
Facility:____________City:__________________
Facility:____________ City:__________________
Facility:____________ City:__________________

ID number/case number (if available):
____

Parent/Guardian/Other Support Person:
Name:____________________________________
Phone # or other contact info:______________
____
Relationship:______________________________

ACTIVE DIAGNOSES :

ALERTS :

Doctor or clinic before evacuation (if known):
Name:_____________________________________
City:_________________________ State:______

ALLERGIES :

ACTIVE MEDICATIONS

Name of pharmacy chain (if known):

Medication:
Instructions:

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Please note encounters on reverse side →

Healthcare Encounters

Date	Location & Clinician Name	Symptoms/Diagnoses	Tests/ Results	Treatment and Follow-up Needs

Immunizations received since evacuation:

(Attach immunization card if you have one)

Other: