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| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **MY HEALTH SUMMARY** | | | | | | | | | | | | | |
| **NAME: Address:**  **Phone Number(s):**  **Date of Birth:**  **Blood Type: Weight: Safety Alert:** | | | | | | | | | | | | | |
| **CONTACT Name** | | | | | | **Phone Number** | | | | **Address** | | | |
|  | | | | | |  | | | |  | | | |
| **LEGAL GUARDIAN:** | | | | | |  | | | |  | | | |
| **MEDICAL INSURANCE** | | | | | **Policy Number** | | | | | | **Group Number** | | |
|  | | | | |  | | | | | |  | | |
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| **PHYSICIAN(S)** | | **Phone Number** | | | | | **Address** | | | | | **Fax Number** | |
|  | | | | | | | | | | | | | |
| **ALLERGIES / REACTION** | | | | | | | | | | | | | |
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| **MEDICAL CONDITIONS/DIAGNOSIS/BASELINE DATA** | | | | | | | | | | | | | |
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| **ONGOING MEDICAL TREATMENTS/LOCATION/ALTERNATE SITE** | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | |
| **IMMUNIZATIONS** | | | | | | | | | | | | | |
| **Type/Dates** | | | | | | | | | **Type/Dates** | | | | |
|  | | | | | | | | |  | | | | |
| **CURRENT MEDICATIONS** | | | | | | | | | | | | | |
| **Medication** | **Dosage** | | | **How Much/How Often/When Taken** | | | | | | | | | **Doctor who Prescribed** |
|  | | | | | | | | | | | | | |
| **Pharmacy/Address:**  **Pharmacy Phone Number: Fax** **Number:** | | | | | | | | | | | | | |
| **MEDICAL/ MOBILITY AIDS/DEVICES** | | | | | | | | | | | | | |
| **Name** | | | **Vendor** | | | | | **Phone Number** | | | **Electricity/Batteries?** | | |
|  | | | | | | | | | | | | | |
| **DAILY LIVING AIDS/SPECIAL INSTRUCTIONS/SERVICE ANIMAL** | | | | | | | | | | | | | |
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| **COMMUNICATION DEVICES** | | | | | | | | | | | | | |
| **Name** | | | **Vendor** | | | | | **Phone Number** | | | **Electricity/Batteries?** | | |
|  | | | | | | | | | | | | | |