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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** |
|  |  |  |
|  |  |  |
| **PHYSICIAN(S)** | **Phone Number** | **Address** | **Fax Number** |
|  |
| **ALLERGIES / REACTION** |
|  |
| **MEDICAL CONDITIONS/DIAGNOSIS/BASELINE DATA** |
|  |
| **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** |
|  |
| **COMMUNICATION DEVICES** |
| **Name** | **Vendor** | **Phone Number** | **Electricity/Batteries?** |
|  |