Personal Medical Information Form

Name:	Date of Birth:
Street:	Social Security Number:
City:	Citizenship:
State/Province:	Passport Number:
Postal/Zip Code:	Telephone Number:
Country:	E-mail:

Health Insurance Plan **Supplemental / Travel Insurance Plan**

Provider:	Provider:
Member ID Number:	Member ID Number:
Street:	Street:
City:	City:
State/Province:	State/Province:
Postal/Zip Code:	Postal/Zip Code:
Telephone Number:	Telephone Number:
E-mail:	E-mail:

Doctor **Hospital**

Name:	Name:
Street:	Street:
City:	City:
State/Province:	State/Province:
Postal/Zip Code:	Postal/Zip Code:
Telephone Number:	Telephone Number:
E-mail:	E-mail:

Emergency Contact Person(s)

Name:	Name:
Relationship:	Relationship:
Street:	Street:
City:	City:
State/Province:	State/Province:
Postal/Zip Code:	Postal/Zip Code:
Telephone Number:	Telephone Number:
E-mail:	E-mail:

Present & Past Medical Conditions

Allergies & Drug Sensitivities **Blood Type**

Blood Type

Medications

Name (generic)	Dose	Schedule

Vaccines & Preventative Medications

Type	Yes	No	Date Last Received
Routine Immunizations:			
DTP, Td (diphtheria-tetanus-pertussis)			
Haemophilus influenza B (sepsis)			
Influenza			
MMR (measles-mumps-rubella)			
Pneumococcus (pneumonia)			
Polio			
Varicella zoster (chicken pox, shingles)			
*Other: (as determined by destination)**			

*Cholera, hepatitis A, hepatitis B, immune globulin, Japanese encephalitis, malaria prophylaxis, meningococcal meningitis, plague, rabies, tick-borne encephalitis, tuberculosis, typhoid fever, yellow fever

If you have a history of heart disease please attach a copy of a recent **EKG**.

Provide a copy of this form to family members and emergency contact designees.

Take this form with you when you seek medical attention.