

WORK SHEETS

A. PHYSICAL/MEDICAL INFORMATION

Medical records for families are normally maintained at a hospital or medical treatment facility. Make a copy of your medical record so you will have it. The information presented in this worksheet is generally needed in an emergency or for school. For proof of immunizations, an International Health Booklet validated by a doctor is recommended for school and international travel.

FOR MEMBER: NAME _____

VITAL STATISTICS:

Age: _____ Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Distinguishing Marks/Physical Characteristics: _____

MEDICAL INFORMATION:

Blood Type: _____ Adverse Drug Reactions (if not, write NONE): _____

Allergies (if not, write NONE): _____

Organ Donor? Yes _____ No _____ Tissue Donor? Yes _____ No _____

If yes, location of donor authorization form(s): _____

Any religious information or considerations which would have a bearing on medical treatment: _____

Other Important Medical Data: _____

FOR SPOUSE: NAME _____

VITAL STATISTICS:

Age: _____ Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____

Distinguishing Marks/Physical Characteristics: _____

MEDICAL INFORMATION:

Blood Type: _____ Adverse Drug Reactions (if not, write NONE): _____

Allergies (if not, write NONE): _____

Organ Donor? Yes _____ No _____ Tissue Donor? Yes _____ No _____

If yes, location of donor authorization form(s): _____

Any religious information or considerations which would have a bearing on medical treatment: _____

Other Important Medical Data: _____

NAME _____

VITAL STATISTICS:

Age: _____ Height: _____ Weight: _____ Hair Color: _____ Eye Color: _____
 Distinguishing Marks/Physical Characteristics: _____

MEDICAL INFORMATION:

Blood Type: _____ Organ Donor? Yes _____ No _____ Tissue Donor? Yes _____ No _____
 If yes, location of donor authorization form: _____

Any religious information or considerations which would have a bearing on medical treatment: _____

DISEASES HAD:	YES	NO	DATE	EXAMINATIONS	DATE
Chickenpox	_____	_____	_____	Physical Exam	_____
Mumps	_____	_____	_____	Dental Exam	_____
Red Measles (10-Day Or Rubeola)	_____	_____	_____	Eye Exam	_____
Rubella (3-day or German Measles)	_____	_____	_____	Hearing Test	_____
Polio	_____	_____	_____	Tuberculin Test(s)	_____
Rheumatic Fever	_____	_____	_____		_____
Scarlet Fever	_____	_____	_____		_____

MEDICAL ALERT: Please Check All That Apply:

Cardiac Bee Sting Diabetes Hemophilia Seizure (Epilepsy) Ulcer
 Allergy, Type _____
 Asthma _____
 Other _____

Chronic or Recurring Illnesses: _____

Medication to be Taken at School: _____

Prescription Medication Taken Regularly: _____

IMMUNIZATIONS: For proof of immunizations, an International Health Booklet validated by a doctor is recommended for school and international travel.

Diphtheria Pertussis & Tetanus (DPT)

1st YES NO
 2ND YES NO
 3RD YES NO
 Booster YES NO
 Booster YES NO
 Booster YES NO

Oral Polio: 1st YES NO
 2ND YES NO
 3RD YES NO
 Booster YES NO
 Booster YES NO
 Red Measles (10-day or Rubeola) YES NO
 Rubella (3-day or German Measles) YES NO
 Mumps YES NO

Other important medical information: _____