AT-A-GLANCE MEDICAL SUMMARY

Name _____ Birthdate _____ Blood Type _____

Medical Conditions & Treatments _____

_____

_____

_____

Medication with Doses _____

_____

_____

_____

Allergies, Including Reactions and Treatment _____

_____

_____

_____

Family Medical History _____

_____

_____

_____

AT-A-GLANCE EMERGENCY SUMMARY

Preferred Hospital _____

Who to Contact: Name & Phone_____ Name & Phone_____

MEDICAL CONTACTS

Primary Doctor _____

Specialists _____

Dentist _____

Pharmacy _____

Insurance _____

HEALTH INSURANCE

Primary Insurance (Company Name & ID number) _____

Summary of benefits insurance details _____

Co-pay _____ Deductible _____

Secondary Insurance (Company Name & ID number) _____

Summary of benefits insurance details _____

Co-pay _____ Deductible _____

Prescription (Company Name & ID number)

Co-pay _____ Deductible _____

Misc. _____

_____

_____