Medical BINDER

To use in conjunction with the Family Binder & the Always Prepared Binder!

Over 10 free printables for personal use only.

from WWW.THIRTYHANDMADEDAYS.COM

MEDICAL Binder

VITAL INFO

Name: _____

Date of birth: _____

SSN: _____

Weight: _____

Height: _____

Blood type: _____

Diagnosis(es).: _____

Allergies: _____

Primary Dr.: _____

Dr. Phone #: _____

Dr. Address: _____

Dentist Name: _____

Dentist Phone #: _____

Dentist Address: _____

Insurance Name: _____

Insurance Policy #: _____

Insurance Phone #: _____

MEDICAL RECORD

Name: _____

MEDICATIONS

NAME OF MEDICINE	DOSE	FREQUENCY	DATE STARTED	DATE ENDED	NOTES

SURGERIES

SURGERY TYPE	DATE	DOCTOR	LOCATION	NOTES

ILLNESS/DIAGNOSIS

ILLNESS/DIAGNOSIS	DATE DIAGNOSED	DOCTOR	NOTES

FAMILY HISTORY

MOTHER'S SIDE

	NAME	BIRTHDATE	ILLNESS/CONDITION	AGE/CAUSE OF DEATH
MOTHER				
MATERNAL GRANDMA				
MATERNAL GRANDPA				
SIBLING				
SIBLING				

FATHER'S SIDE

	NAME	BIRTHDATE	ILLNESS/CONDITION	AGE/CAUSE OF DEATH
FATHER				
PATERNAL GRANDMA				
PATERNAL GRANDPA				
SIBLING				
SIBLING				

MY FAMILY

	NAME	BIRTHDATE	ILLNESS/CONDITION	AGE/CAUSE OF DEATH
ME				
SIBLING				
SIBLING				
SIBLING				
SIBLING				

STEP BY STEP

IN CASE OF AN EMERGENCY:

STEP 1: _____

_____

STEP 2: _____

_____

STEP 3: _____

_____

STEP 4: _____

_____

Things to keep in mind:

_____

_____

Things to help comfort:

_____

_____

INCIDENTS

DATE	SEEN BY	INCIDENT	NOTES

DOCTOR VISITS

DATE	SEEN BY	REASON FOR VISIT	NOTES

SPECIALISTS

SPECIALIST NAME	PHONE #	TYPE OF SPECIALIST	NOTES

SPECIALIST APPOINTMENTS

DATE	SPECIALIST	REASON FOR VISIT	NOTES	FOLLOW UP?

HOSPITAL VISITS

DATE	SEEN BY	REASON FOR HOSPITAL VISIT	NOTES

WELL CHECK UPS

Name: _____

AGE	DATE	HEIGHT	WEIGHT	NOTES

WELL CHECK UPS

Name: _____

AGE	DATE	HEIGHT	WEIGHT	NOTES

VACCINATIONS

DATE	NAME	DATE	NAME

PRESCRIPTIONS

DATE	SEEN BY	PRESCRIPTION	NOTES

PHONE CALLS

DATE	PHONE # & DR.	REASON FOR CALL	NOTES

MEDICAL RELEASE

Parent/Guardian Name: _____

Address: _____

Important Phone #'s: _____

_____

Kids Names & Important Info:

FULL NAME	BIRTHDATE	ILLNESS, ALLERGIES, MEDICINES, ETC

In case of an emergency contact:

Name: _____

Relationship: _____

Phone #: _____

DOCTOR INFO

Primary: _____

Address: _____

Phone #: _____

DENTIST INFO

Dentist: _____

Address: _____

Phone #: _____

INSURANCE INFO

Company Name: _____

Policy Number: _____

Phone #: _____

MEDICAL RELEASE

To Whom It May Concern:
As parent/guardian, I do hereby authorize the treatment of a qualified and licensed Medical Doctor in an emergency which, in the opinion of the attending physician, may endanger his/her life, cause disfigurement, physical impairment, or undue discomfort if delayed. This authority is granted only after a reasonable effort has been made to reach me.

Name of Minor:_____ Relationship to you: _____
Reason for which release is intended: _____
Address of Minor: _____
Phone: _____ Emergency Phone: _____
Family Physician:_____ Phone: _____
Physician Address: _____City: _____
List allergies, medications, contract, etc:

_____
_____
_____

Health Insurance Information:
Company:_____ Policy:_____
Group:_____Contract:_____
This release form is completed and signed of my own free will with the sole purpose of authorizing medical treatment under emergency circumstances in my absence.
Date:_____ Signed:_____

To be completed by Notary:
State of:_____Subscribed and sworn to before me
County of _____ This_____ day of _____

_____
Notary Public