Indiana Division of Mental Health and Addiction All Hazards Committee
District Mental Health Response Team
Medical Information Form

General Information

Name____Nickname___________________

Address____State_________

Date of Birth___________________________ Sex: _______Male _______Female

Social Security Number_____-_______-______ Home Telephone___________________

Office Telephone____________________________ Cell Phone_________________________

Email: Work ____________________________ Home ____________________________

Physical Characteristics

Hair Color___________ Eye Color __________ Weight__________

Height__________

Medical Information

1. Current health condition including chronic conditions as follows

Health Conditions Check)	Allergies (check and state specifics)
_____Asthma	_____Insect stings
_____Diabetes Type A or B	_____Foods
_____Epilepsy	_____Food Intolerance
_____Hypertension	_____Medications
_____Other Conditions	_____Other Allergies

Comments on conditions above

____

____

____

2. Prescribed medication ____

____

____

3. Over the counter medication____

____

4. Date of last Tetanus shot ____

____

____

5. Types and date of other vaccinations (please attach copies of documents)

____

____

6. Additional Information for anyone who may need to provide medical treatment

____

____

7. General Health Condition

____

____

Personal Physician Information

Name(s) of primary care physician/partners(s)_____________________________________

____

Address____

Telephone number(s)___________________________ Email_______________________

Emergency Contacts

1. Name______________________________Relationship______________________

Phone: Home __________________________Work ____________________________

E-mail________________________________

2. Name _____________________________Relationship ______________________

Phone: Home _________________________ Work ____________________________

E-mail________________________________

Insurance Information

Health Insurance Provider____

Insurance ID#______________________ Group#______________________________

Authorization for Medical Treatment (if unable to give permission) and Use of Form

Should illness or an accident require emergency medical treatment during my travel (dates) __________________________ and I am unable to supply this medical information or authorize treatment, I authorize____________________responsible for this event to share information as deemed appropriate, and to seek transport and medical treatment by a physician, surgeon, or other health care personnel in the state or country in which I am located.

I assume responsibility for updating this information as needed. I have provided this information voluntarily.

I have also given this form to my emergency contact person ______________________

Signature____

Name (Please Print) ____

Date ____