

Louisiana Volunteers for Family & Community, Inc.
PERSONAL MEDICAL RECORD

Please return with registration form

PLEASE PRINT

I understand this information given by me will be kept confidential and used only in case of a medical emergency

NAME _____

ADDRESS _____

PHONE _____ DATE OF BIRTH _____ FEMALE ___ MALE ___

In case of emergency please contact:

NAME _____ PHONE _____

PHYSICIAN'S NAME _____ PHONE _____

24 HOUR PHONE _____ HOSPITAL _____

INSURANCE _____ MEMBER # _____

GROUP POLICY# _____ MEDICARE # _____

MEDICAL HISTORY:

List all medications taken regularly including prescriptions, over the counter, vitamins & herbals
PLEASE PRINT

NAME of MEDICATION as written on the bottle	DOSAGE in milligrams or ounces	TIMES A DAY (1 tablet x 3)

DRUG ALLERGIES _____

FOOD ALLERGIES _____

All of the above information is correct & up to date.

Signed _____ DATE _____