MY PORTABLE MEDICAL SUMMARY

Name:_____ Date of Birth:_____

Mailing Address	Email Address	Home Phone	Cell Phone

Insurance		Subscriber Name and #
	Primary	
	Secondary	Subscriber Name and #

Legal Health POA	Name	Relationship	Cell #	Work #	Home #	Other
	Name	Relationship	Cell #	Work #	Home #	Other

DOB	Social Sec #	Height	Weight	Blood Type	DNR Signed	Advanced Directives	Organ Donor

NOTES:	
Health Issues	

Medications	Herbs/Drops	Other Equipment

Medical History

Specialty	Procedure	Description

Immunizations (what, when)

Physicians

Specialty	Name	Phone Number	Address/Website

Other

Provided by Texas Parent to Parent