Your Personal Information

Your name: ______________________

DOB: __________ Height: ______ Weight: ______

Phone (home): __________ Cell Phone: __________

Parent's/Guardian's name: __________

Phone: __________

Health insurance co.: __________

ID #: __________ Group #: __________

Your main language or way to communicate: __________

Your Emergency Contacts

Name: __________

Relationship: __________ Phone: __________

Name: __________

Relationship: __________ Phone: __________

Name: __________

Relationship: __________ Phone: __________

Name: __________

Relationship: __________ Phone: __________

Special Instructions

Special safety instructions, crisis plans, or hotline phone #: __________

Special conditions, treatment challenges, unusual findings, or need to use medical or durable equipment (type and size): __________

Your Diagnosis

Main diagnosis: __________

Other diagnosis or major injuries? __________

Special conditions/remarks: __________

Allergies (Include medicine, food, environment, contact, or other. Describe what happens.): __________

Your Doctors

Primary doctor's name: __________

Address: __________

Phone: __________

Preferred hospital: __________

Pharmacy name: __________

Address: __________

Phone: __________

Specialty hospital: __________

Your Doctors

Other health care providers (For example, specialists, dentists, therapists, etc.)

Provider's name: ____________________

Type: ____________________ Phone: ____________

Provider's name: ____________________

Type: ____________________ Phone: ____________

Provider's name: ____________________

Type: ____________________ Phone: ____________

Your Medications

Name of medication	Dose	Frequency

Other

More information: ____________________

Info Sharing

Family members, guardians, or others allowed to discuss your medical information with your doctor. (If 18 years or older, include them on the HIPAA privacy form your doctor gives you.)

Name: ____________________

Relationship: ____________ Phone: ____________

Name: ____________________

Relationship: ____________ Phone: ____________

Name: ____________________

Relationship: ____________ Phone: ____________

Health Information Document

H.I. Doc

Keep your card up to date. To get a new card, visit the NYS Department of Health website at: health.ny.gov/community/special_needs/#

The purpose of this card is to help parents of children with disabilities and people with disabilities organize their health and medical information.

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