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**_________________________