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PORTABLE MEDICAL SUMMARY: NAME:_____

NAME:	**BIRTH DATE:**
ADDRESS:	PARENT/GUARDIAN:
	HOME/WORK PHONE:
PRIMARY LANGUAGE:	EMERGENCY CONTACT:
	PHONE NUMBER (S):
PERTINENT PERSONAL CHARACTERISTICS:	

MEDICATIONS		**Allergies:**	**REACTIONS:**
DAILY Rx:	**MONTHLY Rx:**		
Rx PRN:		**HERBS/SUPPLEMENTS:**	
OXYGEN: YES☐ NO☐ **QUANTITY:**_____			
IMMUNIZATIONS UP TO DATE: YES☐ NO☐		**IMMUNIZATION RECORD (PLEASE ATTACH)**	

PRIMARY DIAGNOSIS:	**AGE AT TIME OF DIAGNOSIS:**
OTHER DIAGNOSIS:	

Hospitalizations/Surgeries/Procedures	**Date:**	**Hospital Name:**	**Physician:**

BASELINE VITALS:	**BASELINE NEUROLOGICAL STATUS:**
RESPIRATIONS_____ **TEMP**_____ **O2**_____ **PULSE**_____ **BP**_____/_____	
BASELINE FINDINGS:	

COMMON PRESENTING PROBLEMS:	**TREATMENT CONSIDERATIONS:**
1.	1.
2.	2.

PORTABLE MEDICAL SUMMARY: NAME:_____

PRIMARY CARE PHYSICIAN:	EMERGENCY PHONE:
	FAX:
OTHER PHYSICIAN:	**OTHER PHYSICIAN:**
EMERGENCY PHONE: FAX:	EMERGENCY PHONE: FAX:
OTHER PHYSICIAN:	**OTHER PHYSICIAN:**
EMERGENCY PHONE: FAX:	EMERGENCY PHONE: FAX:

MEDICAL EQUIPMENT:	**MEDICAL SUPPLIES:**	**PROVIDER:**	**CONTACT INFO:**

NUTRITION/FITNESS GOALS:	**PROVIDER:**	**CONTACT INFO:**

FUNCTIONAL CAPABILITIES: BRIEF SUMMARY	**FUTURE PLANS:** AGENCIES INVOLVED/REFERRALS MADE

SERVICES CURRENTLY RECEIVING:	**PROVIDER CONTACT INFO:**

HEALTH INSURANCE PRIMARY:	**HEALTH INSURANCE SECONDARY:**
NAME:	NAME:
PHONE:	PHONE:

OTHER COMMENTS:

Signature Parent/Guardian:_____ Date:_____

Signature Primary Care Provider_____Phone:_____