

Keep It With You

PERSONAL MEDICAL INFORMATION FORM

In an emergency situation, people may not be able to get to their medical records. The **“Keep It With You” (KIWY) Personal Medical Information Form** is intended to be a voluntary and temporary record that lists medical care and other health information for people who need care during disasters and similar situations. It is important for health care workers to have a simple and reliable way to learn information about past and new health concerns for people receiving help.

Directions:

Please print out Side 1 & 2 of the KIWY Personal Medical Information Form. The KIWY form should be copied so that it is on 2 sides of one piece of paper.

Please fill out as much as you can on the form. It is okay if you don't fill out every space. You might want to use a pencil if some information will change, such as your address. Some of the information will be filled out by a health care worker, like “Active Diagnoses” and “Healthcare Encounters” information. If you have an immunization card listing the shots you have recently had, please staple it to the KIWY form.

The KIWY form can be folded and placed in a plastic bag for safe keeping.

For Health Care Workers:

The KIWY form is not intended to replace hardcopy or electronic medical records, but is an interim communication tool to assist individuals as they navigate a potentially complex system of temporary support, housing, and clinical services. Clinicians are encouraged to adapt format and content as necessary to best serve the specific situation, population, and clinical care needs. The form provided is intended to serve as a basic tool, providing a framework for more specific refinement.

It is suggested that care providers **photocopy** the document after an individual receives care, in order to maintain a record of who was seen and what treatment was provided. The original form is intended to **remain with the individual** during the time they are displaced. The form can serve as an interim summary when normal care can be resumed.



Please print the following pages and **Keep It With You**.

NAME: _____

Date of Birth: ____/____/____

Male _____ Female _____

E-mail: _____

Home Address: _____

City: _____

State: _____ Zip: _____

Phone Number: _____

Temporary Address: _____

City: _____

State: _____ Zip: _____

Phone Number: _____

Previous evacuee center location(s):

Facility: _____ City: _____

Facility: _____ City: _____

Facility: _____ City: _____

ID number/case number (if available):

Parent/Guardian/Other Support Person:

Name: _____

Phone # or other contact info: _____

Relationship: _____

ACTIVE DIAGNOSES :

ALERTS :

Doctor or clinic before evacuation (if known):

Name: _____

City: _____ State: _____

ALLERGIES :

ACTIVE MEDICATIONS

Name of pharmacy chain (if known):

Medication:

Instructions:

Medication:

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Please note encounters on reverse side →

Healthcare Encounters

DATE	LOCATION & CLINICIAN NAME	SYMPTOMS/DIAGNOSES	TESTS/ RESULTS	TREATMENT AND FOLLOW-UP NEEDS

Immunizations received since evacuation:

(Attach immunization card if you have one)

Other: