

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 fill in as much information 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 information will be filled out by a health care worker, like "Active Diagnoses" and "Health Care Encounters" information. If you have an Immunization Card listing the shots you have had recently, please staple it to this form. You can store this form 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 people as they navigate a potentially complex system of temporary support, housing, and clinical services. Clinicians are encouraged to adapt this format and content as necessary. It is suggested that care providers **photocopy** the document after an individual receives care, in order to maintain a record of their treatment. The original form is intended to **remain with the individual** during the time they are displaced.

HOW TO CONTACT US

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KEEP IT WITH YOU

PERSONAL MEDICAL INFORMATION FORM

FOR PEOPLE WHO NEED CARE DURING DISASTERS

*This pamphlet can be kept
in a plastic bag for
safe keeping in case of
an emergency*

www.chesapeakehc.org

HEALTHCARE ENCOUNTERS

Date _____ **Location** _____
Symptoms/Diagnoses _____

Tests/Results _____
Treatment/Follow-up Needs _____

Date _____ **Location** _____
Symptoms/Diagnoses _____

Tests/Results _____
Treatment/Follow-up Needs _____

Date _____ **Location** _____
Symptoms/Diagnoses _____

Tests/Results _____
Treatment/Follow-up Needs _____

Date _____ **Location** _____
Symptoms/Diagnoses _____

Tests/Results _____
Treatment/Follow-up Needs _____

Date _____ **Location** _____
Symptoms/Diagnoses _____

Tests/Results _____
Treatment/Follow-up Needs _____

Notes: _____

PERSONAL INFORMATION

Name _____
Date of Birth ____ / ____ / ____ Male ____ Female ____
E-mail address _____
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 _____
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 EVALUATION (if known):

Name _____
City _____ State _____

ALLERGIES:

ACTIVE MEDICATIONS

Name of pharmacy chain (if known) _____

Medication _____
Instructions _____
Medication _____
Instructions _____
Medication _____
Instructions _____
Medication _____
Instructions _____
Medication _____
Instructions _____
Medication _____
Instructions _____
Medication _____
Instructions _____
Medication _____
Instructions _____
Medication _____
Instructions _____
Medication _____
Instructions _____

Immunizations received since
Evacuation _____

Attach immunization card if you have one.