

LAST REVIEWED/UPDATED:

Review and update this form at least once a year.



# Medical Information

NAME \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_ GENDER \_\_\_\_\_

ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP \_\_\_\_\_

PHONE \_\_\_\_\_

## Emergency Contacts

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

PET CARE \_\_\_\_\_ PHONE \_\_\_\_\_

## Doctors

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

DENTIST \_\_\_\_\_ PHONE \_\_\_\_\_

PREFERRED HOSPITAL \_\_\_\_\_ PHONE \_\_\_\_\_

## Caregiver/Support

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

## Vaccines

- FLU
- PNEUMOCOCCAL
- TETANUS/PERTUSSIS
- COVID-19 BRAND
- SHINGLES

## Drug or Other Allergies

_____	_____
_____	_____
_____	_____
_____	_____

## Medications

	PURPOSE	DOSE & FREQUENCY	PRESCRIBING DOCTOR
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
OVER THE COUNTER	_____	_____	_____
VITAMINS/SUPPLEMENTS	_____	_____	_____

## Advance Directives

- LIVING WILL
- DURABLE POWER OF ATTORNEY
- LONG-TERM CARE INSURANCE POLICY

Place Where Kept \_\_\_\_\_

## Important Medical History

Review your TRS beneficiaries regularly. Keeping this information current can help protect your loved ones.



Store this document in a secure location, and make sure a trusted person knows how to find and access it.