PAGE 1 - This Health Profile form should open in Adobe Reader. **Save** this original file to your computer. Next we recommend you Save this file again but Rename it to include the User's name or initials. **Fill out** this 2-page form by clicking in the areas you wish to fill out. Re-Save frequently while filling it out. To Print, go to the print dialogue box and **UN**check the grayscale B&W option. Click the "Printer" tab at bottom, check box for "2-sided" or "Print on both sides of paper." Specify "Short-Edge binding" or "Flip on Short Edge." **Print. Trim** on dotted lines, fold into a tri-fold, insert into your MediPal ID holder and secure to the user's seatbelt.

Thank you for being a part of the MediPal ID family. Take good care.

The MediPal® Seatbelt ID

Saving Time Saves Lives

MediPal Inc.

I have DIABETES Type ___

This is a screen-fillable PDF form. Find it here:

www.medipal.com/insert/diabetes

The purchaser/user assumes full responsibility for the accuracy of information provided, the placement of the MediPal® ID on user's safety belt or physical self, and/or any harm produced by the MediPal® ID itself or from any contents placed in or attached to the MediPal® ID. Information provided which results in disclosure of information to unwanted parties or resulting in identity theft is the sole responsibility of the purchaser/user.

My Personal Information:

My Name:

____

My Nickname: ______________________

My Date of Birth: ______________________

My Address:

____

My Home Phone: ______________________

My Cell Phone: ______________________

My Pet(s) & location: ______________________

____

Location of my Health Care Directive:

____

Family's meeting place away from home:

My Emergency Contacts:

(Consider listing one out-of-town contact.)

Parent/Caregiver 1:

____

Phone: ______________________

Parent/Caregiver 2:

____

Phone: ______________________

My Healthcare Power of Atty.: name/phone

____

My Automobile Insurance Company:

Name: ______________________

Phone: ______________________

Policy #: ______________________

My Medical Insurance Company:

Name: ______________________

Phone: ______________________

Member I.D.#: ______________________

My Primary Doctor:

Name: ______________________

Phone: ______________________

My Specialty Doctor:

Name: ______________________

Phone: ______________________

My Dentist:

Name: ______________________

Phone: ______________________

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PAGE 2 - This Health Profile form should open in Adobe Reader. **Save** this original file to your computer. Next we recommend you Save this file again but Rename it to include the User's name or initials. **Fill out** this 2-page form by clicking in the areas you wish to fill out. Re-Save frequently while filling it out. To Print, go to the print dialogue box and **UN**check the grayscale B&W option. Click the "Printer" tab at bottom, check box for "2-sided" or "Print on both sides of paper." Specify "Short-Edge binding" or "Flip on Short Edge." **Print. Trim** on dotted lines, fold into a tri-fold, insert into your MediPal ID holder and secure to the user's seatbelt.

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My Diagnosis:

(Pre-diabetic)

❑ **Type 1 Diabetes**
as of: ____________

❑ **Type 2 Diabetes**
as of: ____________

Use Insulin Pump?: ❑ Yes ❑ No
Location of Pump?: ____________________

Use Insulin Injections?: ❑ Yes ❑ No
Location of Syringe/Pen?: ____________________

Optimum Level (Range) of Blood Sugar is: ____________________

Preferred Treatment for Hypoglycemia: ❑ Fruit Juice/drink ❑ Sugar
❑ Regular Soda (not diet) ❑ Honey ❑ Glucose Tablets ❑ P-nut Butter
❑ Other: ____________________

My Medications:

As of this date: ____________________

(Include the Names and Dosages of all prescriptions, herbal and homeopathic medicines.)

My Pharmacy name & phone: ____________________

Other Medical Conditions:

(Recent hospitalizations, stroke, heart attack, etc.)

Covid Vaccine Received?: ❑ Yes ❑ No
If "Yes" which vaccine?: ❑ Pfizer ❑ Moderna ❑ Other: ____________________

More Information:

My Primary Language is:

____

I Communicate By:
❑ Voice ❑ Sign Language ❑ Gestures
❑ Picture ICONS ❑ Written Word
❑ Communication Device ❑ Interpreter

My Blood Type: ____________

My Weight: ______ My Height: ______

❑ Hearing loss ❑ Wear hearing aids
❑ Vision loss ❑ Wear Glasses

My Allergies:

to food & medication:
(Include a description of side effects)

Special Diet:

My Preferred Hospital:

____

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