

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

### Three Lower Counties Community Services Inc.

12137 Elm Street  
Princess Anne, MD 21853

Dental  
410-651-5151

12145 Elm Street  
Princess Anne, MD 21853

Internal Medicine  
Ob/Gyn  
Pediatrics  
410-651-1000

Mental Health  
410-651-2204

1104 Healthway Drive  
Salisbury, MD 21804

Internal Medicine  
Ob/Gyn  
Pediatrics  
Mental Health  
410-219-1100

305 Tenth Street, Suite 104  
Pocomoke City, MD 21851

Internal Medicine  
Pediatrics  
410-957-1852

[www.tlccs.org](http://www.tlccs.org)



## 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.tlccs.org](http://www.tlccs.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 \_\_\_\_\_  
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Instructions \_\_\_\_\_

Immunizations received since Evacuation \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Attach immunization card if you have one.*