Medical Go Bag Checklist

Documents

- [ ] Medical History Document (included)
- [ ] Copy of Identification: Driver's license, etc
- [ ] Copy of Health Insurance Card
- [ ] Copy of Advance Directive or Power of Attorney
- [ ] Pet Care Information Document (included)

Comfort

- Dentures carrying case
- Assistive device, if applicable
- Favorite book
- Scrabble, Sudoku, games
- Cellphone/iPad/Tablet and chargers
- Paper and pen
- Picture of loved ones
- Comfort item from home
- Nonslip slippers/slip-on shoes

Extras

- Extra shirt, pants and underwear
- Spare house key
- Spare hearing aids with batteries
- Spare pair of glasses or contacts
- Foods, if applicable
- Refillable water bottle

medical reserve corps vermont

VERMONT DEPARTMENT OF HEALTH

Printable Bag Loop

Print and cut out with scissors.

Attach to Medical Go Bag.

Belongs to: _____

Medical Go Bag

Contains Important Medical Necessities - Keep On Person

Belongs to: _____

Medical Go Bag

Contains Important Medical Necessities - Keep On Person

Belongs to: _____

Medical Go Bag

Contains Important Medical Necessities - Keep On Person

Medical History

Patient Information		Preferred language:
Name:	DOB:	Gender:
Address		Phone

Emergency Contact #1		
Name	Relationship	Phone

Emergency Contact #2		
Name	Relationship	Phone

Emergency Contact #3		
Name	Relationship	Phone

Insurance Information	
Insurance Provider	Policy number

Personal History (*Check all that apply*)

- ☐ No known medical conditions
- ☐ Allergies (Drug, Food, Environmental)
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Blood transfusion
- ☐ Cancer (Specify: _____)
- ☐ Congestive heart failure
- ☐ COPD / Emphysema
- ☐ Depression
- ☐ Diabetes (Type 1 / Type 2)
- ☐ Epilepsy / Seizures
- ☐ GERD (Acid Reflux)
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack / Heart Disease
- ☐ High Blood Pressure (Hypertension)
- ☐ High Cholesterol
- ☐ HIV / AIDS
- ☐ Kidney Disease / Kidney Stones
- ☐ Liver Disease / Hepatitis
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Stroke
- ☐ Substance Abuse (Alcohol / Drugs)
- ☐ Thyroid Disease (Hypo / Hyper)
- ☐ Tuberculosis
- ☐ Ulcers

Other medical issues:

Treatments/Medications

Name(s)	Dosage(s)	Frequency	Purpose	Note(s)

Treatments/Medications				
Name(s)	**Dosage(s)**	**Frequency**	**Purpose**	**Note(s)**

Dietary restrictions:	**Allergies:**

Family History (*Check all that apply*)

☐ No known family history of medical conditions	☐ Stroke
☐ Cancer	☐ Thyroid Disease
☐ Diabetes	☐ Kidney Disease
☐ Heart Disease	☐ Mental Health Conditions (Depression, Anxiety, etc.)
☐ High Blood Pressure	☐ Autoimmune Diseases
☐ High Cholesterol	☐ Other: ----------

Name of Primary Care Provider (PCP): **Phone number and address of PCP:**	**Additional health information:**

Surgeries/Procedures (with dates):

Name of pharmacy:

Phone number of pharmacy:

Address of pharmacy:

Please use this page to share any other important patient information for the medical team:

Care information for Pet

Pet's Name:	Add a picture of your pet here
Sex: / **Age:**	
Breed:	
Coloring:	

Food Info

Please include all food information relevant to your pet below. Including food brand, amount and frequency of meals below.

Potty Break

Please include all information relevant to your pet's bathroom business below.

Additional info

Please include any additional information about your pet, such as outside time and/or medication information below. Vet information, such as, name, address, phone number.

Pet's contact person and phone number: