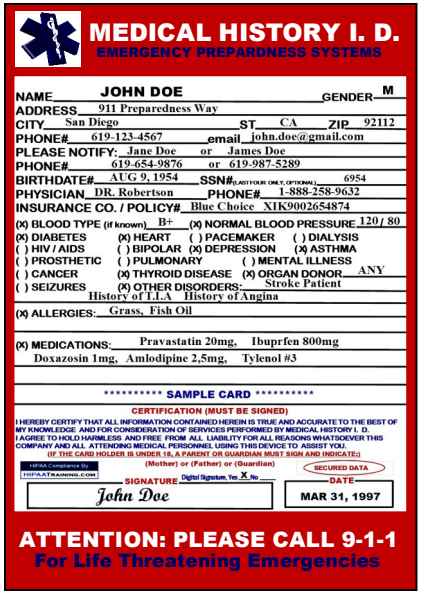
The **MEDICAL HISTORY I. D. CARD!** A wallet-size card with a unique readable microfilm insert stating your Emergency Medical History. **NO EQUIPMENT IS NEEDED TO READ IT!** If you become suddenly ill or in an accident and can't speak, the **MEDICAL HISTORY I. D.** can help speak for you. Any Emergency Medical Personnel or Doctors can respond quickly in an emergency with information such as your Blood Type, Heart Trouble, Pulmonary Problems, and drug allergies, or any other pre-existing conditions that is listed on your card. Even if you're in perfect health, you should carry this unique card because it shows that you have no pre-existing conditions and emergency care may begin quickly. **MEDICAL HISTORY I. D.** can help support the difference between life and death.

**Prepare Now, Survive Later! = When Seconds Count!**



**MEDICAL HISTORY I. D.**
EMERGENCY PREPAREDNESS SYSTEMS

NAME JOHN DOE GENDER M
ADDRESS 911 Preparedness Way
CITY San Diego ST CA ZIP 92112
PHONE# 619-123-4567 email john.doe@gmail.com
PLEASE NOTIFY: Jane Doe or James Doe
PHONE# 619-654-9876 or 619-987-5289
BIRTHDATE# AUG 9, 1954 SSN# (LAST FOUR ONLY, OPTIONAL) 6954
PHYSICIAN DR. Robertson PHONE# 1-888-258-9632
INSURANCE CO. / POLICY# Blue Choice X1K9002654874
(X) BLOOD TYPE (if known) B+ (X) NORMAL BLOOD PRESSURE 120 / 80
(X) DIABETES (X) HEART ( ) PACEMAKER ( ) DIALYSIS
( ) HIV / AIDS ( ) BIPOLAR (X) DEPRESSION (X) ASTHMA
( ) PROSTHETIC ( ) PULMONARY ( ) MENTAL ILLNESS
( ) CANCER (X) THYROID DISEASE (X) ORGAN DONOR ANY
( ) SEIZURES (X) OTHER DISORDERS: Stroke Patient History of T.I.A History of Angina
(X) ALLERGIES: Grass, Fish Oil
(X) MEDICATIONS: Pravastatin 20mg, Ibuprfen 800mg Doxazosin 1mg, Amlodipine 2,5mg, Tylenol #3

********** SAMPLE CARD **********

CERTIFICATION (MUST BE SIGNED)
I HEREBY CERTIFY THAT ALL INFORMATION CONTAINED HEREIN IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND FOR CONSIDERATION OF SERVICES PERFORMED BY MEDICAL HISTORY I. D. I AGREE TO HOLD HARMLESS AND FREE FROM ALL LIABILITY FOR ALL REASONS WHATSOEVER THIS COMPANY AND ALL ATTENDING MEDICAL PERSONNEL USING THIS DEVICE TO ASSIST YOU.
(IF THE CARD HOLDER IS UNDER 18, A PARENT OR GUARDIAN MUST SIGN AND INDICATE:)
(Mother) or (Father) or (Guardian)
HIPAA Compliance By HIPAATRAINING.COM
SECURED DATA
SIGNATURE Digital Signature, Yes X No
John Doe
DATE
MAR 31, 1997

**ATTENTION: PLEASE CALL 9-1-1**
**For Life Threatening Emergencies**

1. Please print legibly and accurately to eliminate mistakes as this information is vital and can help save your life.
2. If your card is lost or needs updating, you can reorder a replacement card for a nominal fee of $7.99, with your last order on file. For each additional card of the same order the cost is $6.99 each, you may order up to 5 cards at this price.
3. Allow two to three weeks for delivery and online order.
4. Retain this portion as your receipt. This is a excellent start for **EMERGENCY and NATARUL DISASTER PREPAREDNESS.**

**ONLY $14.99 EACH, TAX, S & H INCLUDED**

**Instructions:** Please fill out your Medical History I. D. data form online or use this form and mail to:


**Medical History I. D.**
**5505 Stevens Way, #740131**
**San Diego CA 92174, PH: 1-858-222-4516**
**medicalhistoryid.com**


**PLEASE DETACH AND RETURN THIS PORTION WITH YOUR REMITTANCE**

# MEDICAL HISTORY I. D. DATA FORM

**IMPORTANT – PLEASE READ BEFORE FILLING OUT – FOR BEST RESULTS PRINT LARGE AND PLEASE USE A BLACK INK. THIS INFORMATION MAY HELP SAVE YOUR LIFE.**

**MAKE SURE YOUR INFORMATION IS LEGIBLE AND ACCURATE.**

**PLEASE READ THE CERTIFICATION NOTICE BEFORE SIGNING.**

**FOR OFFICIAL USE ONLY**

| B | 2 | B | C | | | | |
|---|---|---|---|---|---|---|---|

NAME _____ GENDER _____
ADDRESS _____
CITY _____ ST _____ ZIP _____
PHONE# _____ email _____
PLEASE NOTIFY: _____
PHONE# _____
BIRTHDATE# _____ SSN# (LAST FOUR ONLY, OPTIONAL) _____
PHYSICIAN _____ PHONE# _____
INSURANCE CO. / POLICY# _____

( ) BLOOD TYPE (if known) _____ ( ) NORMAL BLOOD PRESSURE ____ / ____
( ) DIABETES ( ) HEART ( ) VACCINATED (J. M. P.) ( ) DIALYSIS
( ) HIV / AIDS ( ) BIPOLAR ( ) DEPRESSION (PTSD) ( ) ASTHMA
( ) PROSTHETIC ( ) PULMONARY ( ) MENTAL ILLNESS
( ) CANCER ( ) THYROID DISEASE ( ) ORGAN DONOR _____
( ) SEIZURES ( ) OTHER DISORDERS: _____

( ) ALLERGIES: _____

( ) MEDICATIONS: _____

**CERTIFICATION (MUST BE SIGNED)**

**I HEREBY CERTIFY THAT ALL INFORMATION CONTAINED HEREIN IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE AND FOR CONSIDERATION OF SERVICES PERFORMED BY MEDICAL HISTORY I. D. I AGREE TO HOLD HARMLESS AND FREE FROM ALL LIABILITY FOR ALL REASONS WHATSOEVER THIS COMPANY AND ALL ATTENDING MEDICAL PERSONNEL OR ANY PERSON USING THIS DEVICE TO ASSIST YOU.**

**(IF THE CARD HOLDER IS UNDER 18, A PARENT OR GUARDIAN MUST SIGN AND INDICATE:)**

HIPAA Compliance By HIPAATRAINING.COM

**(Mother) * (Father) * (Guardian) * (Care Giver w/Approval)**

**SIGNATURE** Digital Signature, Yes ___ No ___ **DATE**