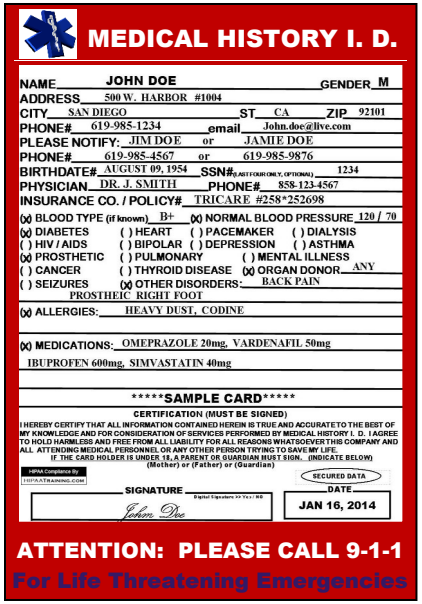
The **MEDICAL HISTORY I. D. CARD** is a wallet-size card with a unique readable microfilm insert stating your Emergency Medical History. **NO EQUIPMENT IS NEEDED TO READ IT!** If you suddenly become ill or in an accident and can't speak, the **MEDICAL HISTORY I. D.** can help speak for you. Any Emergency Medical Personnel or Doctors can respond quickly in an emergency with information such as your Blood Type, Heart or Pulmonary Conditions and all drug allergies, or any other pre-existing conditions that you 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. The **MEDICAL HISTORY I. D.** can help support the difference between life and death.

**Prepare Now, Survive Later >>> When seconds Count!**



**MEDICAL HISTORY I. D.**

NAME JOHN DOE GENDER M
ADDRESS 500 W. HARBOR #1004
CITY SAN DIEGO ST CA ZIP 92101
PHONE# 619-985-1234 email John.doe@live.com
PLEASE NOTIFY: JIM DOE or JAMIE DOE
PHONE# 619-985-4567 or 619-985-9876
BIRTHDATE# AUGUST 09, 1954 SSN# (LAST FOUR ONLY, OPTIONAL) 1234
PHYSICIAN DR. J. SMITH PHONE# 858-123-4567
INSURANCE CO. / POLICY# TRICARE #258*252698
(x) BLOOD TYPE (if known) B+ (x) NORMAL BLOOD PRESSURE 120 / 70
(x) DIABETES ( ) HEART ( ) PACEMAKER ( ) DIALYSIS
( ) HIV / AIDS ( ) BIPOLAR ( ) DEPRESSION ( ) ASTHMA
(x) PROSTHETIC ( ) PULMONARY ( ) MENTAL ILLNESS
( ) CANCER ( ) THYROID DISEASE (x) ORGAN DONOR ANY
( ) SEIZURES (x) OTHER DISORDERS: BACK PAIN
PROSTHETIC RIGHT FOOT
(x) ALLERGIES: HEAVY DUST, CODINE
(x) MEDICATIONS: OMEPRAZOLE 20mg, VARDENAFIL 50mg
IBUPROFEN 600mg, SIMVASTATIN 40mg

*****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 OR ANY OTHER PERSON TRYING TO SAVE MY LIFE.
IF THE CARD HOLDER IS UNDER 18, A PARENT OR GUARDIAN MUST SIGN. (INDICATE BELOW)
(Mother) or (Father) or (Guardian)
HIPAA Compliance By HIPAATRAINING.COM
SECURED DATA
SIGNATURE John Doe
DATE JAN 16, 2014

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

1. If your card is lost or needs updating, you can reorder a replacement card for a nominal fee of $7.99, with your first order on file. For each additional card of the same order the cost is $6.99 and you may order up to 4 cards at this price.
2. Please allow two to three weeks for delivery.
3. Retain this portion as your receipt.
4. Disaster can strike anyone at any time and this is a good start to take time to remember and take time to prepare.

**Preparedness is the key to recovery.**

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

**Instructions:** Please fill out your Medical History I. D. data form and return it with your check or money order to:


**Medical History I. D.**
**P.O. BOX 126633, SAN DIEGO CA 92112**
**PH: 858-222-4516**
**medicalhistoryid.com**


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

# MEDICAL HISTORY I. D. DATA FORM

**IMPORTANT – PLEASE PRINT LEGIBLY AND ACCURATLY TO ELIMINATE MISTAKES, THIS INFORMATION IS VITAL AND CAN HELP SAVE YOUR LIFE. FOR BEST RESULTS, PLEASE USE BLACK INK. THIS INFORMATION IS TO ASSIST THE EMERGENCY PERSONNEL OR DOCTORS THAT WILL PROVIDE MEDICAL CARE TO YOU.**

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

B 2 B C

FOR OFFICIL USE ONLY

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 ( ) PACEMAKER ( ) DIALYSIS
( ) HIV / AIDS ( ) BIPOLAR ( ) DEPRESSION ( ) 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 OTHER PERSON TRYING TO SAVE MY LIFE.**

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

**(Mother) ** (Father)* *(Guardian) ** (Care Giver)**

HIPAA Compliance By HIPAATRAINING.COM

Digital Signature >> YES___ / NO___

LAST UPDATE

**SIGNATURE** **DATE**