The MediPal® Seatbelt ID

is brought to you by

BLEEDING DISORDERS FOUNDATION
OF NORTH CAROLINA

My MediPal® ID

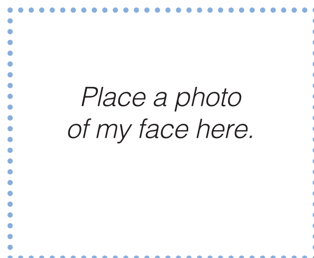
I have a **Bleeding Disorder**

You can edit this text!

Find this screen-fillable PDF form here:
https://bleedingdisordersnc.org/seatbelt-strap-program/

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.)

1st Emergency Contact relation: ______________
Name: ______________________
Phone: ______________________

2nd Emergency Contact relation: ______________
Name: ______________________
Phone: ______________________

My Healthcare Power of Attorney:
Name: ______________________
Phone: ______________________

My Automobile Insurance Company:
Name: ______________________
Phone: ______________________
Policy #: ______________________

My Medical Insurance Company:
Name: ______________________
Phone: ______________________
Member I.D.#: ______________________

My Primary Doctor:
Name: ______________________
Phone: ______________________

My Hematologist: ______________
Name: ______________________
Phone: ______________________

My Dentist:
Name: ______________________
Phone: ______________________

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My Diagnosis: ☑ Bleeding Disorder

Bleeding Disorder Type: ______

Other Medical Condition(s):

______

______

______

Primary Language: ______

Treatment Plan In Case of Emergency:

______

______

______

______

______

______

______

______

______

______

______

Other Important Information

______

______

______

My Medical Information:

My Blood Type: ______

My Weight: ______ My Height: ______

❑ Hearing Loss ❑ Wear Hearing Aids

❑ Vision Loss ❑ Wear Glasses ❑ Contacts

My Medications: ✚

As of this date: ______

(Include Names and Dosages of all prescriptions)

______

______

______

______

Taking Hemlibra: ❑ Yes* ❑ No

*See important treatment info enclosed

Has a Port: ❑ Yes ❑ No

My Pharmacy: (name/phone)

______

My Allergies: to food or medication

(Include side effects)

______

______

______

My Preferred Hospital:

______

BLEEDING DISORDERS FOUNDATION OF NORTH CAROLINA

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