

Prepper Survival Group Medical Record Form

Personal Information:

- Full Name: _____
- Date of Birth: _____ Age: _____
- Gender: _____
- Blood Type: _____
- Emergency Contact Name: _____
- Emergency Contact Phone: _____
- Relationship to Contact: _____
- Address: _____
- Known Allergies: _____
- Medications Currently Taken: _____
- Medical Conditions (e.g., Diabetes, Hypertension): _____
- Do you have any disabilities or impairments? Yes / No (If yes, explain)

Vaccination History (Check all that apply):

- Tetanus
- Hepatitis A / B
- MMR (Measles, Mumps, Rubella)
- Influenza
- COVID-19
- Other: _____

Medical History:

- Surgeries: _____
- Past Major Illnesses: _____
- Previous Hospitalizations: _____
- Any Chronic Pain or Mobility Issues: _____

Dietary Restrictions:

Mental Health History (Optional but recommended for group preparedness):

- Any diagnosed mental health conditions? Yes / No (If yes, explain)

- Any history of PTSD, Anxiety, or Depression? Yes / No (If yes, explain)

- Any history of substance use or dependence? Yes / No (If yes, explain)

Skills & Medical Training:

- First Aid / CPR Certified? Yes / No
 - Medical Training or Experience? Yes / No (If yes, explain)
 - Other Relevant Skills (e.g., Herbal Medicine, Wilderness First Aid):
-

Medical Supplies Owned (Check all that apply):

- First Aid Kit
- Prescription Medications (Personal Use)
- Antibiotics
- Trauma Kit
- Sutures / Wound Care Supplies
- Other: _____

Consent & Signature: I, _____, acknowledge that this information is accurate to the best of my knowledge and is provided for emergency preparedness purposes within the survival group.

Signature: _____ Date: _____



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