Emergency Card

LAST NAME:	FIRST:	DATE OF BIRTH:	AGE:	PHONE:
ADDRESS:				

EMERGENCY CONTACT INFORMATION:

RESIDENTIAL CONTACT:	NAME:	☐ PARENT ☐ OTHER FAMILY ☐RESIDENTIAL PROGRAM STAFF ☐SPONSOR ☐ OTHER	
HOME PHONE:	CELL PHONE:	WORK PHONE:	OTHER PHONE:
LEGAL GUARDIAN NAME:		ADDRESS:	
HOME PHONE:	CELL PHONE:	WORK PHONE:	OTHER PHONE:

Other persons who are authorized to act in an emergency and are authorized to pick up or receive drop off of individual.

NAME:	ADDRESS:	RELATIONSHIP TO INDIVIDUAL:	
HOME PHONE:	CELL PHONE:	WORK PHONE:	OTHER PHONE:
NAME:	ADDRESS:	RELATIONSHIP TO INDIVIDUAL:	
HOME PHONE:	CELL PHONE:	WORK PHONE:	OTHER PHONE:
RELATIONSHIP TO INDIVIDUAL:			
CASE MANAGER:		PHONE:	

BACKGROUND INFORMATION:

DIAGNOSIS:	SEIZURES: ☐ NO ☐ YES	ALLERGIES: ☐ NO ☐ YES Specify:	
GENERAL PHYSICIAN NAME:	ADDRESS:	PHONE:	
TUBERCULOSIS STATUS: DATE OF LAST MONTOUX TEST:	RESULTS: ☐ NEGATIVE ☐POSITIVE – IF POSITIVE DATE OF CHEST XRAY:	RESULTS: ☐ NEGATIVE ☐POSITIVE	
HEPATITIS B STATUS:	DATE:	LAST TETANUS IMMUNIZATION DATE:	

INSURANCE INFORMATION:

MEDICAID NUMBER:	MEDICAID HMO (IF APPLICABLE):	
MEDICARE NUMBER:	MEDICARE HMO (IF APPLICABLE):	
OTHER MEDICAL INSURANCE CARRIER:	ID#:	GROUP #:
PRESCRIPTON DRUG INSURANCE COMPANY:		ID#:

HOME REPRESENTATIVE SIGNATURE: _____ **DATE:** _____

MEDICATION INFORMATION: AS OF (DATE):

MEDICATION NAME	DOSE	MEDICATION NAME	DOSE	MEDICATION NAME	DOSE

MEDICATION INFORMATION: AS OF (DATE):

MEDICATION NAME	DOSE	MEDICATION NAME	DOSE	MEDICATION NAME	DOSE

MEDICATION INFORMATION: AS OF (DATE):

MEDICATION NAME	DOSE	MEDICATION NAME	DOSE	MEDICATION NAME	DOSE

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MEDICATION INFORMATION: AS OF (DATE):

MEDICATION NAME	DOSE	MEDICATION NAME	DOSE	MEDICATION NAME	DOSE

MEDICATION INFORMATION: AS OF (DATE):

MEDICATION NAME	DOSE	MEDICATION NAME	DOSE	MEDICATION NAME	DOSE

HOME REPRESENTATIVE SIGNATURE: ____ **DATE:** ____________________________