



Medical Emergency Information

Name: _____ Date of Birth: _____

Street Address: _____ City: _____ Zip: _____

Phone: _____ Lives with: family self group home other

Responsible Party(s) (i.e. mother, father, guardian, etc.):

1. Name: _____ Relationship: _____ Daytime Phone: _____

2. Name: _____ Relationship: _____ Daytime Phone: _____

Provider Agency: _____ Staff name: _____ Daytime Phone: _____

Diagnosis and other medical facts: _____

Current Medications: _____

Date of last tetanus: _____ Code status: _____ Allergies: _____

1. Primary Physician's name: _____ Phone: _____ Fax: _____

Address (Street, City, State, Zip): _____

2. Primary Dentist's name: _____ Phone: _____ Fax: _____

Address (Street, City, State, Zip): _____

Consulting Physicians (i.e. Neurologist, Psychiatrist, etc.):

1. Name: _____ Specialty: _____

Phone: _____ Fax: _____

2. Name: _____ Specialty: _____

Phone: _____ Fax: _____

Emergency Contact Information (Person that may provide transportation if parent/guardian unavailable)

1. Name: _____ Home: _____ Cell: _____ Work: _____

Address (Street, City, Zip): _____ Relationship: _____

2. Name: _____ Home: _____ Cell: _____ Work: _____

Address (Street, City, Zip): _____ Relationship: _____



Medical Emergency Information

Notification/Permission Statements:

(indicate yes or no)

- 1. Health/Behavioral information may be shared with caregivers, family members and health care provider as appropriate according to agency Privacy Practices
2. A non-emergency detailed message may be left as a voicemail.
3. I wish to be notified of any minor/insignificant marks or injuries. (i.e. scratches, paper cut, bruises, hang nail, etc.)
4. I wish to be notified of medical issues/illness of moderate significance (i.e. fever, vomiting, etc.)
5. I wish to be notified of medical issues/illness of severe significance (i.e. need for transfer to hospital)
6. A licensed nurse or trained MCBDD staff may administer emergency medical interventions/ treatments per a physician's order as needed (i.e. CPR, oxygen, Heimlich Maneuver)

*In the event of a life threatening emergency, 911 will be called to transport enrollee to the nearest hospital.

Signatures: _____ / _____ / _____
Applicant (18 yrs or older) Parent if under 18 Court appointed Guardian

Date: _____