Adult Medical Emergency Information

Name: _____ Date of Birth: _____

Street Address: _____ City: _____ Zip: _____ Phone _____

Mother/ Guardian: _____ Daytime phone number: _____

Father/ Guardian: _____ Daytime phone number: _____

Agency Provider: _____ Daytime phone number: _____

Lives with _____ family_____ self _____ group home _____ other

MEDICAL HISTORY

Diagnoses: _____

_____

Current Medications: _____

_____

Date of last tetanus shot: _____ Code Status: _____

Allergies: _____

Other facts concerning the enrollee's medical history: _____

HEALTHCARE INFORMATION

Primary Physician: _____ Phone: _____

Specialist: _____ Phone: _____

Specialist: _____ Phone: _____

EMERGENCY CONTACT

Please specify two alternate emergency contacts that can provide transportation in the event the parent/guardian is unavailable:

Name: _____ Phone: _____ Relationship to Enrollee: _____

Address: _____

Name: _____ Phone: _____ Relationship to Enrollee: _____

Address: _____

I wish to be contacted for (check all that apply)

minor and insignificant injuries or marks. (i.e. scratches, bruises etc.)	____
medical issues of moderate significance (i.e. fever, vomiting)	____
for life threatening issues, major injuries or transfers to the hospital.	____

Indicate YES or NO to the following statements:

A detailed message maybe faxed or left on my answering machine.	☐**YES**	☐**NO**
Health/behavioral information may be shared with a caregiver other than myself.	☐**YES**	☐**NO**
I give my permission for MCBDD staff to share information with other health care professional as appropriate with HIPAA guidelines.	☐**YES**	☐**NO**
I give my permission for a licensed nurse or trained MCB DD staff to administer medications, tube feedings, emergency medical interventions, and/or medical treatments per physician's order while receiving board program services.	☐**YES**	☐**NO**

PLEASE NOTE

- Board services shall not be provided unless a current signed Medical Emergency Information and Consent Form is on file.
- This Medical Emergency Information and Consent Form is valid for one year from date signed below.
- In the event of an emergency, 911 will be called to transport the enrollee for medical care to Medina General Hospital.
- This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for each surgery, are obtained prior to the performance of such surgery.

_____

Signature Date

Copies to MCBDD direct care staff (e.g. transportation drivers, work supervisors, job coaches, etc.)