



# 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: \_\_\_\_\_



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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: