Emergency Card

Last Name	First Name	DOB	Age	Phone
Address				
DDD ID	Case manager	Agency	Phone	

Residential Contact Name	☐Parent ☐Other family ☐Residential program staff ☐Sponsor ☐Other		
Home phone	Cell phone	Work phone	Other
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.

(1)Name	Address	Relationship to individual	
Home phone	Cell phone	Work phone	Other phone
(2)Name	Address	Relationship to individual	
Home phone	Cell phone	Work phone	Other phone

Background information

Diagnosis	Seizures yes no	Allergies yes no Specify:	
Other health conditions:		Preferred hospital:	
General physician name:		Address	Phone
TB test date:	***Result: negative positive Chest xray date/results:***		
Hepatitis B status :	***Date:***	***Date of last tetanus vaccination:***	

Medicaid number:		Medicaid HMO *(if applicable):*
Medicare number:		Medicare HMO *(if applicable):*
Other medical insurance carrier:	ID number:	Group #:
Prescription drug insurance company:		ID#:

_____***Signature of home representative*** _____***Date***

Emergency Card

Medication Information as of ______________(date) ***Must be complete despite whether or not the individual is receiving meds while at program

Medication name	Dose	Medication	Dose	Medication	Dose

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