



EMERGENCY CONTACT/SAFETY INFORMATION

This form is shredded after you leave services.

ID number: (assigned by agency) _____

Date: _____

Name: _____

Cell phone: _____

Emergency Contact Information *(In case there is an emergency, who would you like us to contact?)*

Emergency contact name: _____

Emergency contact phone number: _____

Relationship to emergency contact: _____

Secondary safe contact name: _____

Secondary safe contact number: _____

Relationship to secondary safe contact: _____

Is it safe to leave a message with your emergency contacts? Yes No

Work phone number: _____

In the event of an emergency, is it safe to contact you at work? Yes No

Is it safe to leave a message for you at work? Yes No

Child/children emergency contact name: *(Is the emergency contact different from above if there is an emergency with your children?)*

Child/children emergency contact phone number: _____

Relationship to child: _____

Medical information

Medical/health conditions: *(In case we need to call medical personnel, is there any medical information you would want us to share with them about you or your children?)*

Self: _____

Children: Name: _____

Name: _____

Allergies: *(Do you or your children have any allergies that we should be aware of? Do you have any medications you need in the event of an allergic reaction?)*

Self: _____

Children: Name: _____

Name: _____

Special Needs: *(Do you or your children have any needs that require accommodations or assistance you would like us to be aware of?)*

Self: _____

Children: Name: _____

Name: _____

Selah Place of Oregon County, Inc.

ADDITIONAL EMERGENCY/SAFETY INFORMATION

ID number: (assigned by agency) _____

Date: _____

Name: _____

Safety:

If we have not had any contact with you in _____ (#) of hours/days, would you like for us to:

- Attempt to contact me on my cell
- Attempt to contact me at work
- Contact my emergency contact
- Contact the police
- Take no action to locate me or call others

I have been informed of my right to the confidentiality of my personal information and the risks associated with waiving those rights. I give consent for the release of essential information to the proper authorities in the event:

- A missing person's report has been filed
- Death by suspicious means that may be reasonably considered a result of abuse
- None of the above

Information that can be released to authorities in the event of one of the above is:

- Information about dates and services received
- Information about the person who has harmed me
- Information about abuse experienced
- Other: _____
- None of the above

I confirm that this release of information is valid while I am receiving services from _____ (agency) and _____ (amount of time) after the last service received.

I also understand that I can withdraw my consent at any time, either verbally or in writing.

Survivor signature: _____

Advocate signature: _____

Date: _____

Consent Revoked Date: _____ Advocate Name: _____