**EMERGENCY FORM**

**INSTRUCTIONS :**

(1) Complete all items on this side of the form. Sign and date where indicated.

(2) If your family member/you have a medical condition which might require emergency medical care, complete the back side of the form. If necessary, have the primary health practitioner review that information.

NOTE: THIS ENTIRE FORM MUST BE UPDATED ANNUALLY.

List at least one person who may be contacted to pick up the consumer in an emergency if you are not available:

1. Name Last First

Telephone (H) (W) \_

Address Street/Apt.# City State Zip Code

2. Name Last First

Telephone (H) (W)

Address Street/Apt.# City State Zip Code

3. Name Last First

Telephone (H) (W)

Address Street/Apt.# City State Zip Code

Physician or Source of Health Care

Telephone

Address Street/Apt.# City State Zip Code

In EMERGENCIES requiring immediate medical attention, your relative/you will be taken to the NEAREST HOSPITAL EMERGENCY ROOM. Your signature authorizes the responsible person at the facility to have your relative/you transported to that hospital.

Signature of Parent/Guardian/Advocate/Self Date

\_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_ \_

Consumer’s Name Last First

Birth Date

Enrollment Date

Hours & Days of Expected Attendance

Home Address Street/Apt.# City State Zip Code

Mother’s Name Last First

Home Telephone

Mother’s Employer/School \_ Name Address

Mother’s Home Address (*If different from above)*

Street/Apt.# City State Zip Code

Work Telephone

Cellular Phone

Beeper \_

Father’s Name Last First

Home Telephone

Father’s Employer/School \_ Name Address

Father’s Home Address *(If different from above)*

Street/Apt.# City State Zip Code

Work Telephone

Cellular Phone

Beeper

Name of Person Authorized to Pick Up Consumer *(daily)*

Last First Relationship to Child

Address Street/Apt.# City State Zip Code

**ANNUAL UPDATES**

*(Initials/Date) (Initials/Date) (Initials/Date) (Initials/Date)*

OCC 1214 (Revised 7/05) - Side 1 of 2 - *All previous editions are obsolete.*

**INSTRUCTIONS :**

(1) Complete the following items, as appropriate, if there is a condition(s) which might require emergency medical care.

(2) If necessary, have the health practitioner review the information you provide below and sign and date where indicated.

Consumer’sName:

Date of Birth:

Medical Condition(s):

Medications currently being taken :

Date of last tetanus shot:

Allergies/Reactions:

**EMERGENCY MEDICAL INSTRUCTIONS:**

(1) Signs/symptoms to look for:

(2) If signs/symptoms appear, do this:

(3) To prevent incidents:

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OTHER SPECIAL MEDICAL PROCEDURES THAT MAY BE NEEDED:

COMMENTS:

**Note to Health Practitioner:**

If you have reviewed the above information, please complete the following:

Name of Health Practitioner Date

( )

Signature of Health Practitioner Telephone Number

OCC 1214 (Revised 7/05, 06/13, 02/14) - Side 2 of 2 - *All previous editions are obsolete.*