EMERGENCY MEDICAL INFORMATION

705A Oakwood St, Ravenna, OH 44266

Name: _____ DOB: _____

Address: _____

Primary Phone: _____ Age: _____ SS# _____

Legal Guardian (if applicable): _____ Phone: _____

Guardian's Place of Employment: _____ Fax: _____

Provider: _____ Phone: _____

Primary Diagnosis: _____

Other Diagnosis: __ Seizures __ Diabetic __ Asthma __ Blind/Legally Blind __ Hard of Hearing/Deaf __ Nonverbal

Preferred Doctor: _____ Phone: _____

Specialist: _____ Phone: _____

Specialist: _____ Phone: _____

Specialist: _____ Phone: _____

Preferred Dentist: _____ Phone: _____

Preferred Hospital: _____ Phone: _____

Medicaid Number: _____

Medicare Number: _____

Insurance other than Medicare/Medicaid: YES NO

If yes, company name: _____ Plan ID/Group # _____

EMERGENCY CONTACTS

Emergency Contact #1 _____ Relationship: _____

Home # _____ Work # _____

Cell # _____ Other # _____

Emergency Contact #2 _____ Relationship: _____

Home # _____ Work # _____

Cell # _____ Other # _____

TURN OVER →

List of medications taken daily. Please list both prescribed and over-the-counter medications.

Medication	Amount & Times	Prescribing Doctor

Please list any allergies and the reaction: _____

_____.

Mobility (check all that apply): __ Walks independently __ Walks with device (walker/cane)

__ Walks with assistance of another person __ Wheelchair

__ Wears brace/splints _____ __ Prosthetic _____

The individual may be left home alone: □ YES □ NO

_____ _____

Signature of Acknowledgment Relationship

*We do not know if someone is home unless they are visible. Please make sure you are seen if individual has no alone time.

If the individual has a guardian, the guardian must sign. If there is no guardianship, the individual must sign.

I AUTHORIZE the release of this information to be given to the above named emergency contacts and physicians in the event of a medical emergency.

Signature _____ Date _____

PLEASE NOTE: You will be asked to complete this information at least once per year or when changes in your residence or medication occur. In order to protect the health and safety of individuals, Portage Industries, Inc. and potentially other providers of adult services must have accurate, up-to-date medical information. Failure to complete this form could jeopardize our ability to provide services. Thank you for your assistance.