Wood County Board of DD
Health Supports and Provider Relations - Recreation

EMERGENCY INFORMATION FORM

Participant Name: First _____ Middle _____ Last _____

DOB: _____/_____/_____ Gender (circle): Male Female Phone #_____ [ ] Home [ ] Cell [ ] Work

Resident Address (Street, City, State Zip):

_____

Email: _____

Primary Contact Name: _____Relationship _____

Address (Street, City, State Zip): _____

Phone #_____ [ ] Home [ ] Cell [ ] Work Secondary #_____ [ ] Home [ ] Cell [ ] Work

Email: _____

Secondary Contact Name: _____ Relationship _____

Address (Street, City, State Zip): _____

Phone #_____ [ ] Home [ ] Cell [ ] Work Secondary #_____ [ ] Home [ ] Cell [ ] Work

Email: _____

Other Emergency Contact Name: _____ Relationship _____

Address (Street, City, State Zip): _____

Phone #_____ [ ] Home [ ] Cell [ ] Work Secondary #_____ [ ] Home [ ] Cell [ ] Work

Email _____

Allergies: (food, medication, other):_____

Date of Last Tetanus:_____ DNR in Place: [ ] Yes [ ] No

Diagnoses: _____

Medical Disabilities: [ ] Seizures, Type:_____ Causes/Description: _____

[ ] Diabetes [ ] Other_____

Communication Status:	Hearing Impaired	[ ] Yes	[ ] No	Is Verbal - Speech	[ ] Yes	[ ] No
	Vision Impaired	[ ] Yes	[ ] No	Uses Signing	[ ] Yes	[ ] No
				Communication Device	[ ] Yes	[ ] No

Medication and dosages (please list those given routinely whether given at home or school/work): Add additional sheet if required.

Meds./Dose:_____ Meds./Dose:_____

Meds./Dose:_____ Meds./Dose:_____

Meds./Dose: _____ Meds./Dose: _____

Special Equipment (glasses, braces, hearing aid, etc.):

_____

Any physical limitations: _____

Any identifying marks (birthmarks, etc.): _____

Special Medical and Behavioral Concerns:_____

_____

_____ _____

Signature of Person Completing Form Date