MEDICAL & EMERGENCY INFORMATION

Participant:_____ Date:_____
Home
Address: _____ Phone #: _____
_____ E-mail: _____

Residential Provider: _____ Phone #: _____
Address: _____ E-mail: _____
_____

Guardian: _____ Phone #: _____
Address: _____ E-mail: _____
_____

NSA (Client Rep.): _____ Phone #:_____
Address: _____ E-mail: _____
_____

Emergency Contact: _____ Emerg. Phone #: _____
Alternate Emergency Phone #'s: _____

Medical Alerts (allergies, high blood pressure, diabetic, etc.): _____
_____
_____

Physical Limitations (bending, sitting, standing, etc.): _____
_____

Diet Restrictions: _____
_____

Medications (please list all):

Medication and dosage	Frequency taken	Time taken

(continue on back of page if necessary or attach medication list to this sheet)

Form Completed by: _____