Emergency Information

Participant Information:

Name: _____ Date of Birth: _____ Sex: _____

Address: _____ Disability(s): _____

_____ _____

What assistive devices are used (e.g., wheelchair, walker, communication device, eyeglasses, etc.)?

_____

_____

Is participant on any medications? _____ If yes, complete the following:

1. Name _____ Purpose _____
   Dosage _____ Time(s) _____
   Method of administration _____
   Potential side effects _____

2. Name _____ Purpose _____
   Dosage _____ Time(s) _____
   Method of administration _____
   Potential side effects _____

3. Name _____ Purpose _____
   Dosage _____ Time(s) _____
   Method of administration _____
   Potential side effects _____

Does the participant have a seizure disorder? _____ Are they currently under control? _____

If yes, complete the following:

Type of seizure/symptoms _____
Length/severity _____
Possible triggers _____
Any specific guidelines _____

List any known allergies: _____

Does participant have any other medical concerns, equipment, procedures?

_____

_____

(Please see reverse side)

Parent/Guardian Information

Name: _____ Relationship to Participant: _____

Address: _____ Home Phone: _____

_____ Cellular Phone: _____

Email: _____ Work Phone: _____

Occupation/place of work: _____

Name: _____ Relationship to Participant: _____

Address: _____ Home Phone: _____

_____ Cellular Phone: _____

Email: _____ Work Phone: _____

Occupation/place of work: _____

Emergency Contacts

Name: _____ Relationship to Participant _____
Address: _____ Home Phone: _____

_____

Work Phone: _____ Cellular Phone: _____

Name: _____ Relationship to Participant _____
Address: _____ Home Phone: _____

_____

Work Phone: _____ Cellular Phone: _____

Physician Information

Name: _____ Office phone: _____

Parent/Guardian Signature: _____ Date: _____