PRIMETIME CENTER EMERGENCY CARD

LAST NAME:________________________________ **FIRST:**___________________________ **DOB:**_______________ **DDD ID#:**________________

ADDRESS:____ **PHONE#:**____________________________________

NAME OF LEGAL GUARDIAN/RELATIONSHIP:____

SUPPORT COORDINATOR:____ **PHONE #:**____________________________________

RESIDENTIAL EMERGENCY CONTACT INFORMATION			
NAME:		RELATIONSHIP:	
HOME ADDRESS:			
HOME PHONE#:	CELL#:	WORK #:	OTHER#:

OTHER PERSONS WHO ARE AUHORIZED TO ACT IN AN EMERGENCY AND ARE AUTHORIZED TO PICK UP OR RECEIVE DROP OFF OF INDIVIDUAL

1) NAME:	ADDRESS:		RELATIONSHIP:
HOME PHONE#:	CELL #:	WORK#:	OTHER#:
2) NAME:	ADDRESS:		RELATIONSHIP:
HOME PHONE#:	CELL#:	WORK#:	OTHER#:

BACKGROUND INFORMATION

DIAGNOSIS:	SEIZURES: ☐ YES ☐ NO	ALLERGIES: ☐ YES ☐ NO SPECIFY:
PRIMARY PHYSICIAN:	ADDRESS:	PHONE#:
PREFERRED HOSPITAL:		

INSURANCE INFORMATION

MEDICAID #:	MEDICAID HMO & NUMBER:
MEDICARE #:	MEDICAIRE HMO & NUMBER:
PRIVATE INSURANCE NAME/NUMBER AND GROUP #:	
ASO NAME & NUMBER:	

MEDICAL RESTRICTIONS/SPECIAL INSTRUCTIONS

____

____

____

____

____

MEDICATION INFORMATION AS OF DATE:___________________

MEDICATION NAME | DOSAGE

1)____

2)____

3)____

4)____

5)____

6)____

HOME REPRESENTATIVE SIGNATURE:____DATE_______________________________________