THE ARC FOND DU LAC, INC.

EMERGENCY MEDICAL FORM

ATTACH CLIENT PHOTO HERE

Date Form Completed: _____

1. GENERAL / MEMBER INFORMATION

Full Name: _____ **Sex:** [ ] M [ ] F **DOB:**_____

Address: _____ **Phone:** _____

Client Email: _____ **Living Arrangement:** [ ] Own [ ] AFH [ ] Parents [ ] Other

Parent/Guardian: _____ **Phone:**_____

Guardian Email: _____ **Address:**_____

2. EMERGENCY CONTACT

1. **Name:** _____ **Relationship:** _____ **Phone:**_____

2. **Name:** _____ **Relationship:** _____ **Phone:** _____

3. MEDICAL / DIAGNOSIS INFORMATION

Medical / Physical Diagnosis: _____

Mental / Psychological Diagnosis:_____

4. HEALTHCARE PROVIDERS

Primary Physician: _____ **Phone:** _____

Address: _____

Psychologist / Counselor: _____ **Phone:**_____

Address:_____

Dentist: _____ **Phone:** _____ **Address:**_____

5. MEDICAL DETAILS & MEDICATIONS

Allergies: _____

Seizures: [ ] Yes [ ] No **Staff intervention required:** [ ] Yes [ ] No

Seizure Description / Protocol:_____

Current Medications: [ ] Yes [ ] No (Attach current medication list or list below; update with changes.)

Medication / Dosage / Time: 1._____

2._____

3._____

Last Tetanus Shot: _____ **Advanced Directives (Living Will, POA, DNR):** [ ] Yes [ ] No If yes, attach a copy

6. EMERGENCY MEDICAL AUTHORIZATION

I, _____ (Member / Guardian), give permission for The Arc Fond du Lac, Inc. to pursue any and all emergency medical treatment necessary.

Signature: _____ **Date:** _____

Note: This form must be completed fully and is valid for one year from the date of signature. It must be renewed annually to continue participation in programs.