ARIZONA DEPARTMENT OF ECONOMIC SECURITY
Division of Developmental Disabilities

INDIVIDUAL EMERGENCY INFORMATION – RESIDENTIAL

Medical file and health card will accompany the individual on all routine and emergency medical visits.

Individual's Name *(Last, First, M.I.)*: ______________ Date of Birth: ______ Phone No.: ______

Individual's Address *(No., Street, City, State, ZIP)*: ______________

Sex: M F Race: ______________ Language Spoken/Understood: ______________

Religious Preference: ______________

Day Program Provider's Name: ______________ Phone No.: ______

Day Program Provider's Address *(No., Street, City, State, ZIP)*: ______________

Physician's Name: ______________ Phone No.: ______

Physician's Address *(No., Street, City, State, ZIP)*: ______________

Hospital's Name: ______________

Pharmacy's Name: ______________ Pharmacy's Phone No.: ______

Pharmacy's Address *(No., Street, City, State, ZIP)*: ______________

Primary Health Insurance: ______________ I.D./Policy: ______________ Phone No.: ______

Secondary Health Insurance: ______________ I.D./Policy: ______________ Phone No.: ______

AUTHORIZATION PROCESS

Call the PCP when taking a client to emergency. PCP will then call the hospital to authorize emergency treatment.

Guardian's Name: ______________ Phone No.: ______

Guardian's Address *(No., Street, City, State, ZIP)*: ______________

OTHER CONTACTS IF GUARDIAN IS UNAVAILABLE

Parents' Name(s): ______________ Phone No.: ______

Parents' Address *(No., Street, City, State, ZIP)*: ______________

Support Coordinator's Name: ______________ Phone No.: ______

Means of Communication: ______________

General Health Status: ______________

Health Risk and Procedure to Follow: ______________

Allergies: ______________

Type of Seizure Disorder: ______________ Frequency of Seizure Activity: ______________

Behavior Risk: Yes No Explain: ______________

What to Do: ______________

Antecedent: ______________

Level II Behavior Program: Yes No Additional Information: ______________

Completed By: ______________ Date Completed: ______________

See **Medication Treatment Plan** for medication dosage, side effects and lab schedule.

Reference **Helpful Hints** form for additional information pertinent to this individual.

Equal Opportunity Employer / Program • Auxiliary aids and services are available upon request to individuals with disabilities • To request this document in alternative format or for further information about this policy, contact the Division of Developmental Disabilities ADA Coordinator at 602-771-2893; TTY/TDD Services: 7-1-1 •