



Senior Community Service Employment Program

**Emergency Medical Information**

Name of PARTICIPANT					
Street Address:					
City:			State:		Zip:
Telephone: ( ) -		Age:		Date of Birth: / /	
<i>Please provide us with the names of PEOPLE TO CONTACT in case of an emergency.</i>					
<b>First Choice:</b>					
Name:			Relationship:		
Street Address:					
City:			State:		Zip:
Telephone (home): ( ) -		(work): ( ) -		, ext.	
<b>Second Choice:</b>					
Name:			Relationship:		
Street Address:					
City:			State:		Zip:
Telephone (home): ( ) -		(work): ( ) -		, ext.	
<i>Please describe any MEDICAL CONDITION that should be reported to paramedics in the event of any medical emergency (include any allergies).</i>					
<i>Are you taking any MEDICATIONS? <input type="checkbox"/> Yes ; <input type="checkbox"/> No</i>					
<i>If YES, please list name, dosage, and how often you take each medication.</i>					
1.		2.		3.	
4.		5.		6.	
7.		8.		9.	
10.		11.		12.	
Your Doctor's Name:			Phone #: ( ) -		
Hospital Preference:					
Ambulance Preference:					
<i>I give permission for this information to be used by emergency practitioners in the event that I experience an emergency.</i>					
					/ /
Participant Signature					Date Signed