

IN CASE OF EMERGENCY FORM

Date Form Completed: _____

Current Age: _____

INFORMATION IS FOR:

Last Name: _____

First Name: _____

Middle Initial: _____

Date of Birth: _____

Current Age: _____

UWIOC Student ID: _____

Address of Student: _____

Practicum Site: _____

Blood Type: _____

OTHER PERSONAL INFORMATION:

Height: _____ Weight: _____

Hair Color: _____ Eyes: _____

Pacemaker: () yes () no

Eye Glasses/Contact lens: () yes () no

TWO FAMILY MEMBERS TO CONTACT IN CASE OF EMERGENCY:

Name: _____

Address: _____

Relationship to student: _____

Telephone contact & Email: _____

Name: _____

Address: _____

Relationship to student: _____

Telephone contact & Email: _____

PHYSICIAN:

Primary Care Doctor: _____

Address: _____

Telephone Number: _____

Emergency Service _____

Specialist (identify)

City: _____

Telephone Number _____

Emergency Service _____

HOSPITAL(s):

Name the *preferred hospital* or one covered by your insurance

If necessary transport me to the following hospital:

INSURANCE:

Primary

Carrier (i.e. Beacon etc) _____

Policy # _____ Group # _____

Policy Holder's Name: _____

Phone: _____

Pre-Certification Phone: _____

Secondary

Carrier _____

Policy # _____ Group # _____

Policy Holder's Name: _____

Phone: _____

Pre-Certification Phone: _____

OTHER PERTINENT DOCUMENTS/INFORMATION:

If applicable, attach document to this sheet

Do Not Resituate () yes () no

Organ Donor: () yes () no

Medical Power of Attorney:

Person Designated: _____

Telephone Number _____

Cell Phone/Pager # _____

CHRONIC MEDICAL CONDITION(s):

(Identify, i.e. Huntington's Disease, Cancer, Congestive Heart Failure, Diabetic I or II, Emphysema, Epilepsy, Seizures, Kidney or Liver disease etc.)

Condition: _____

Diagnosed: _____

Specialist: _____

Condition: _____

Diagnosed: _____

Specialist: _____

OTHER MEDICAL CONDITIONS:

(Identify i.e. Hearing Loss, Blind, Anemia, Thyroid Disease, High Blood Pressure, etc.)

Condition: _____

Diagnosed: _____

Specialist: _____

Condition: _____

Diagnosed: _____

Specialist: _____

VACCINATIONS: Year of last vaccination

___ Tetanus/diphtheria

___ Pneumococcal vaccine

___ Flu vaccine

___ Measles, mumps, rubella

___ Polio

___ Chickenpox

___ Hepatitis A

___ Hepatitis B

ALLERGIC TO - DO NOT GIVE:

(List everything i.e. Morphine causes rash, etc.)

Allergic to: _____

Reaction: _____

Allergic to: _____

Reaction: _____

Allergic to: _____

Reaction: _____

SPECIAL INSTRUCTIONS:

Identify i.e.: Keep Calm/Tends To Hyperventilate When Excited-Seizure Prone;

Do Not Use Restraints; Keep Head Elevated/Swallowing Difficulties, etc.

CURRENT PRESCRIPTION MEDICATION(s):

ADDITIONAL CONTACTS: - (To Be Made By Family, **Not** EMS, I.e. employer, other emergency contacts, funeral homes, clergy, etc.)

Organization: _____

Person To Contact _____

Telephone No. _____

Organization: _____

Person To Contact _____

Telephone No. _____

Organization: _____

Person To Contact _____

Telephone No. _____

STUDENT'S DECLARATION

I _____ declare that I do not suffer or have never suffered from any type of mental illness.

Student's signature: _____

Date: _____