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:_____