IMPORTANT PHONE NUMBERS

EMERGENCY CALL 911

DOCTOR: ADDRESS: PHONE: ( ) -	**POISON CONTROL CENTER**: PHONE: ( ) -
DENTIST: ADDRESS: PHONE: ( ) -	**HOSPITAL**: ADDRESS: PHONE: ( ) -
EMPLOYER #1: EMPLOYER NAME: EMPLOYER ADDRESS: MOBILE: ( ) - OFFICE PHONE: ( ) - EMAIL ADDRESS:	**EMPLOYER #2:** EMPLOYER NAME: EMPLOYER ADDRESS: MOBILE: ( ) - OFFICE PHONE: ( ) - EMAIL ADDRESS:
ALTERNATE CONTACT NAME: PHONE: ( ) - RELATIONSHIP:	**ALTERNATE CONTACT** NAME: PHONE: ( ) - RELATIONSHIP:
EMERGENCY/EVACUATON MEET UP INSTRUCTIONS:	

In an emergency, when all phone circuits are busy, text messaging may still be operable.

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CARE RECIPIENT'S PERSONAL INFORMATION

Name: Date of Birth:
Sex: Hair:
Eyes:
Allergies:

Medical Conditions/Medication:

2ND CARE RECIPIENT'S PERSONAL INFORMATION

Name: Date of Birth:
Sex: Hair:
Eyes:
Allergies:

Medical Conditions/Medication:

MEDICAL INSURANCE INFORMATION

Name of Insured: Employer:
Ins. Company:
Member No.:
Insured/Employee ID:
Group #: Confirmation Phone No.: ( ) -

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT:

In the case of accident or illness, should _____ become ill during the time that s/he is in the care of _____ (name of caregiver) or suffers an accident of any character, I (we) shall be contacted immediately. In the event that I (we) cannot be contacted immediately, the above named caregiver shall be authorized to secure such medical attention and care as may be necessary from duly licensed medical and dental personnel.

Responsible Party's Signature: _____ Date:

PLEASE ATTACH A COPY OF INSURANCE AND PRESCRIPTION PLAN IDENTIFICATION CARDS

AUTOMOBILE INSURANCE INFORMATON

Ins. Company: Policy ID:
PHONE: ( ) -