Emergency Sheet
(BLACK INK only, please)

Participant: ________________________________ ***DOB:*** ___________ _____

Emergency Contacts, Names & Phone #'s:

____ ______________________________________

Medical Information

Seizure: ☐ Y ☐ N ***Type:*** __________________________

How often: ____Typical Duration: _______________

Appearance: ____

Warning Signals: ____

Medical Treatments or Monitoring: ____

____

Diagnosis:____

OTC Meds Routinely Taken:____

______________________ ________________________ ________________________

Medications: (List can be attached)

Name: _________________________ Dosage: _________ Times Taken: ____________

Name: _________________________ Dosage: _________ Times Taken: ____________

Name: _________________________ Dosage: _________ Times Taken: ____________

Name: _________________________ Dosage: _________ Times Taken: ____________

Name: _________________________ Dosage: _________ Times Taken: ____________

Name: _________________________ Dosage: _________ Times Taken: ____________

Medication Side Effects:____

____

Allergies to Medications: ____

Special Care (glasses, hearing loss, diabetic, etc)
Needs:____

ALLERGIES: ____

Level of Monitoring:____
(1:1 is not provided but a family member/staff may attend outing so participant is able to attend outing)

Name of person completing form: ___________________________________***Date*:** _____________

Name: ______________________ Dosage: ________ Times Taken: ___________
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