Community Respite Program
Emergency Information

Clients Name:_____ Phone:_____
Address:_____
DoB:_____ Sex: _____Social Security_____
Medicare#:_____ Medicaid#:_____
Other insurance:_____

Emergency contact:_____ Relations:_____
Address:_____
Home phone#_____ work#:_____ cell#:_____

Special needs:
Difficulty with _____hearing _____speech ____vision ____swallowing ____breathing
_____following instructions ___other_____
Safety Precautions:_____
Assistance needed _____needs reminders only _____supervision in bathroom
Medical Information: (Please attach a separate sheet if more space is needed)

Significant Medical issues	Prescribed Medications
_____	_____
_____	_____
_____	_____
_____	_____

Allergies:_____
Dietary Restrictions:_____
Primary Care Physician:_____
Physician phone number:_____

Signature of Responsible Party:_____
Date last reviewed:_____
THIS DOCUMENT SHOULD BE REVIEWED FOR ACCURACY AT THE BEGINNING OF EACH RESPITE VISIT.