



<u>Home Address</u>	DOB: _____
	<u>Hmo</u>
	<u>Hospital</u>
<u>Physician</u>	<u>Hospital Phone</u>
Emergency Treatment Consent?	Date Signed: _____

Identification Numbers

CA ID # _____ Exp. Date _____ Medical # _____ Medicare # _____ Hmo # _____

Conservatorship

Legal Status _____ Conservator _____ Home # _____ Work # _____ Cell # _____

Emergency Contacts

1 _____	Home Phone _____	Work Phone _____	Cell /pager _____
2 _____	Home Phone _____	Work Phone _____	Cell /pager _____
3 _____	Home Phone _____	Work Phone _____	Cell /pager _____

Medical Characteristics

Primary Disability _____	Physical Limitations _____	Asthma: _____	Diabetetes: _____
Secondary Disability _____	_____	Heart Disease: _____	Fatigues Easily: _____
Allergies _____	Health Limitations _____	Kidney Disease: _____	Frequent Headaches: _____
_____	_____	Okay For Swimming ? _____	_____
Type Of Seizure _____	Procedure For Seizures _____	Okay For Adaptive Pe ? _____	_____
Date Of Last Seizure _____	_____	_____	_____
Communication Level _____	_____	_____	_____
Alternative Communication _____	_____	_____	_____

Medications

Medication	Dosage	Dosages Time	Maximum Time Without	Reason For Medication

Transportation Information

Primary Transportation _____ Bus Company _____ Phone _____

Alternative Transport 1 _____ Relationship _____ Home Phone _____ Work Phone _____

Alternative Transport 2 _____ Relationship _____ Home Phone _____ Work Phone _____

Additional Comments