

IDD COMMUNITY SUPPORT EMERGENCY INFORMATION

Name _____ Case # _____

Address _____ City/Zip _____

Phone (Home) _____ Phone (Work) _____

Phone (Cell) _____ Medicaid #: _____

Individual/Parent and/or Guardian _____

*Please list your choice of your Community Support Provider – your selection must be from the Gulf Coast Center – Personal Provider Pool or Contracted Agencies. **(Please Print Names)**:*

1) _____ contact number (____) _____

EMERGENCY INFORMATION

Emergency Phone # _____

Physician: _____ Phone # _____

Hospital: _____ Phone # _____

Allergies: _____(yes) _____(no)

Medications (list): _____

Foods (list): _____

Medical Conditions that staff need to be aware of: ie: Seizures, Diabetes, High Blood Pressure etc. _____

NAME OF MEDICATION <small>(If Generic is substituted, list generic medication name)</small>	DOSEAGE <small>(mg.ml.etc.)</small>	PURPOSE OF MEDICATION

FIRE DEPT. 911 POLICE 911 EMS 911 POISON CONTROL 800-764-7661

IDD SERVICE COORDINATOR _____

IDD PROVIDER OF SERVICE STAFF _____

DETAIL ANY SPECIAL SERVICES TO BE PROVIDED (specify)

EATING ASSISTANCE TOILETING EXERCISING

ADAPTIVE AIDS DIETARY NEEDS/CONCERNS

SPECIAL CARE/NEEDS/CONCERNS:

Denote any special trainings required to address specific care or needs:
