Emergency Medical Service Information

Name:____**Date of birth**:___________**Weight**: ________ lbs

Parent/Guardian:_____________________________________**Phone number**:_______________________

Emergency contact & phone (if different):____

Address: ____

Allergies:____

Current medications:____

____

Current medical condition/disability(include physical and cognitive ability/mental health diagnosis):_______________

____

____

Mobility: (choose one) ○ Independent ○ Modified Independence (use of walker, cane or device)

○ Assistance needed ○ Dependent

Wheelchair (please check one): ○Yes or ○No : if yes, ○Power wheelchair or ○ Manual wheelchair

Means of communication (Verbal, use of pictures, device, etc):____

If communication device, is it attached to wheelchair? ○ Yes or ○No

Vision or Hearing concerns:____

DNR/ Ohio Comfort Care: ○Yes or ○No **Living Will** : ○Yes or ○No

Medical Power of Attorney: ○Yes or ○No

Special considerations (e.g. behavioral concerns, and suggested approach to dealing with those concerns):

____

____

____

____

Physician and/or Hospital preference and phone:____

Consent to Release or Share Information

I, _____________________________________(self, parent, or guardian), do herby give the representatives of Rob's Rescue permission to share the above information among one another for the purpose of emergency service planning.

____ _______________________

Signature of Self or Parent/Guardian **Date**

Please return to:	**GCBDD** **Attn: Delana Zapata** **245 N. Valley Rd.** **Xenia, OH 45385**