Client Emergency Contact Information Form

Please complete this form to ensure we have up-to-date emergency contact and medical information on file. This form is designed for printing and manual or digital completion.

1. Client Information

Last Name:		First Name:	
Date of Birth:	MM/DD/YYYY	Phone Number:	
Street Address:		City, State, Zip:	

2. Primary Emergency Contact

Full Name:		Relationship:	
Primary Phone:		Alternate Phone:	
Email Address:			

3. Secondary Emergency Contact

Full Name:		Relationship:	
Primary Phone:		Alternate Phone:	
Email Address:			

4. Medical & Physician Information

Primary Physician Name:		Physician Phone:	
Preferred Hospital:			
Key Medical Conditions:	e.g., Asthma, Diabetes		
Allergies:	e.g., Penicillin, Peanuts		
Current Medications:			

5. Authorization for Emergency Medical Treatment

In the event of an emergency, I hereby authorize the staff to secure necessary medical treatment for the client named above if the emergency contacts cannot be reached.

Client/Guardian Signature:	Sign here after printing	Date:	MM/DD/YYYY