

# Congregational Emergency Health Contact Form



Name:	DOB:	
Address:		
Address:	Driver's License#:	
Home Phone:	Cell:	
Work Phone:	E-mail Address:	
Health Insurance Provider:	Policy Number	
<b>In the event of an emergency, who is to be contacted first?</b>		
Name:	Phone (1)	Phone (2)
Do you live alone: <input type="checkbox"/> Yes <input type="checkbox"/> No		
If no, please list the names of people in your household:		
_____		
_____		
_____		
If you or anyone in your household might require special health care, medical attention or transportation in an emergency situation, please provide details here:		
Local Emergency Contact   Name:	Phone:	
Out-of-town Emergency Contact   Name:	Phone:	
Closest Preferred Hospital:	Phone:	
Closest Neighbor   Name:	Phone:	
Employer Contact   Name:	Phone:	
School Emergency Contact   Name:	Phone:	
Person in congregation most likely to know your whereabouts?		
Name:	Phone:	
Primary Family physician:   Name:	Phone:	
Public Health Department:	Phone:	
Pharmacy(s):	Phone:	
What is your blood type? _____		
Health conditions that could be impacted by a disruption of services of your typical health care providers:		
Please list any drug allergies:		
Have you been told that your immune system is "compromised?" <input type="checkbox"/> Yes <input type="checkbox"/> No		
Do you take medication for this? <input type="checkbox"/> Yes <input type="checkbox"/> No		
List Prescription Medications you take daily by name and dosage.		
_____		
_____		
_____		
Are you on insulin injections? <input type="checkbox"/> Yes <input type="checkbox"/> No		

(Over)

Are you on any IV medications?  Yes  No

If yes, are they administered by a "visiting health professional"?  Yes  No

If yes, do you administer them yourself?  Yes  No

Are you on dialysis?  Yes  No If yes, times per week?

Facility where you receive treatment:

Name: \_\_\_\_\_ Location: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you use routinely oxygen:  Yes  No

Equipment/Oxygen Co: \_\_\_\_\_ Phone: \_\_\_\_\_

Are you on a restricted or special diet?  Yes  No

If Yes, please describe: \_\_\_\_\_

Do you have pets in the home?  Yes  No If yes, list and describe:

What is your source of:

Water:  City  Well  Cistern  Other:

Heating:  Electric  Natural Gas  Propane Gas  Combination / Other:

Cooling:  Electric  Natural Gas  Propane Gas  Combination / Other:

What routine deliveries of essentials are made to your home? List:

Do you have advanced directives (Living Will, DNR, etc.):  Yes  No

Where is a copy kept? \_\_\_\_\_

Do you have any funeral pre-arrangements:  Yes  No

Where is a copy kept? \_\_\_\_\_

Do you have a Medical Power of Attorney?  Yes  No

If yes, Name: \_\_\_\_\_ Phone: \_\_\_\_\_

If you spend a portion of the year residing someplace other than your permanent residence, please estimate dates and time period and provide contact information for that location below.

Dates / Time Period for Seasonal/Alternate Location: \_\_\_\_\_ to \_\_\_\_\_

Seasonal Emergency Contact / Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Nearest Hospital: \_\_\_\_\_ Phone: \_\_\_\_\_

Closest Neighbor / Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Contact / Name: \_\_\_\_\_ Phone: \_\_\_\_\_

School Contact / Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary / Family physician: / Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Public Health Department: \_\_\_\_\_ Phone: \_\_\_\_\_

Pharmacy(s): \_\_\_\_\_ Phone: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_