## EMERGENCY INFORMATION AND MEDICATION FORM

**Participant Name:** _____ **Date of Birth:** _____ **Form Completion Date:** _____

### PRIMARY CONTACT INFORMATION

| Parent/Guardian/Representative #1 | Parent/Guardian/Representative #2 |
|---|---|
| Name: | Name: |
| Address: | Address: |
| Phone(s): | Phone(s): |
| Email: | Email: |
| ***For participants <u>18 yrs and older</u>, indicate if this contact is Legal Guardian or Medical POA.**** ☐ **Yes** ☐ **No**<br>***For participants 18 yrs and older, indicate if you have a DNR/advanced directive.*** ☐ **Yes** ☐ **No**<br>**(Please provide copy of DNR/advanced directive)** | ***For participants <u>18 yrs and older</u>, indicate if this contact is Legal Guardian or Medical POA.**** ☐ **Yes** ☐ **No** |

***If there is a Legal Guardian or Medical POA for a participant 18 and older, that is not listed above, please provide the contact information here:**

**Name:** _____ **Phone:** _____ **Email:** _____

### EMERGENCY CONTACT INFORMATION

Please list at least 1 person (other than those above) to be contacted in case of an emergency.

| | | | |
|---|---|---|---|
| Name: | Relationship: | Phone: | Alt. Phone: |
| Name: | Relationship: | Phone: | Alt. Phone: |

### MEDICAL CONTACT INFORMATION

| | |
|---|---|
| Insurance Name: | Policy Number: |
| Subscriber Name: | Subscriber DOB: |
| Physician Name: | Physician Phone: |

**EMERGENCY INFORMATION AND MEDICATION FORM – PG. 2**

**Participant Name:** _____ **Date of Birth:** _____ **Form Completion Date:** _____

**MEDICAL INFORMATION**

| **List any Health Conditions** | **List any Medication/Food Allergies** |
|---|---|
| | |

**Will the participant be taking any medication during program hours?** ☐ **Yes** ☐ **No**

**If yes, please complete MEDICATION DOSAGE CHART – PG. 3**

**OVER-THE-COUNTER (OTC) MEDICATIONS**

VFES has the following standing orders for OTC medications to be administered during program hours and at the discretion of the program nurse/staff on an as needed basis:

**Acetaminophen, Ibuprofen, Benadryl, Tums, First Aid Cream, Vaseline, Calamine Lotion, Insect Sting Swabs, Ophthalmic Drops, and Hydrocortisone Cream 1%**

Please indicate any OTC medications the participant ***MAY NOT*** have: _____

_____

***I hereby authorize VFES program staff to administer OTC medication(s) as indicated above.***

**Signature:** _____ **Printed** _____

**Name: Relationship (circle): Parent Guardian Self** **Date:** _____

**MEDICATION DOSAGE CHART – PG. 3**

**This page *MUST* be completed if the participant will be taking prescription and/or OTC medication during program hours.**

**Participant Name:** _____ **Date of Birth:** _____ **Form Completion Date:** _____

List each medication that the participant will be taking during program hours (prescription and OTC). Indicate when medication should be taken, including dosage information and route. Please be sure to specify if a medication is to be taken at an exact time or a time other than listed below. Include additional pages as needed.

**All medications should be sent in their original containers and sealed in a large Ziploc bag labeled with participant name.**

**Only send the number of dosages needed for the session, plus one extra dose.**

| Medication Name | Dose | Route | Breakfast (9am) | Lunch (12:30pm) | Dinner (6pm) | Bedtime (9pm) | PRN | Special Instructions |
|---|---|---|---|---|---|---|---|---|
| ***Example:*** *Abilify* | *10mg (1 tablet)* | *By Mouth* | *X* | | *X* | | | *Take with food* |
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**If the instructions listed above differ from the label on the bottle, please explain:** _____

_____

***I hereby authorize VFES program staff to administer medication(s) according to the schedule listed above.***

**Signature:** _____ **Printed Name:** _____

**Relationship (circle): Parent Guardian Self** **Date:** _____