EMERGENCY CARE INFORMATION – FORM D

In case of an emergency, every attempt will be made to contact a parent/guardian or a designated emergency contact.

Name (Last, First, Middle)

Date of Birth	Social Security Number	Passport Number
Language Spoken at Home		Blood Type

RESIDES WITH: (circle one) **MOTHER** **FATHER** **BOTH** **LEGAL GUARDIAN**

MOTHER	ADDRESS	TELEPHONE
Last ________________________________	______________________________________	Home ( ) ____________________
First________________________________	______________________________________	Work ( ) ____________________
Middle ______________________________	______________________________________	Cell ( ) ____________________
FATHER		
Last ________________________________	______________________________________	Home ( ) ____________________
First________________________________	______________________________________	Work ( ) ____________________
Middle ______________________________	______________________________________	Cell ( ) ____________________
LEGAL GUARDIAN		
Last ________________________________	______________________________________	Home ( ) ____________________
First________________________________	______________________________________	Work ( ) ____________________
Middle ______________________________	______________________________________	Cell ( ) ____________________

LIST 2 PERSONS (AT LEAST ONE OF WHICH SHALL RESIDE IN THE WASHINGTON, DC AREA) THAT WE SHOULD CALL IN AN EMERGENCY, IF THE PARENT(S)/GUARDIAN CANNOT BE REACHED.

NAME OF PERSON	RELATIONSHIP	TELEPHONE
1. ____________________________________	______________________________________	________________________________
2. ____________________________________	______________________________________	________________________________

ADDITIONAL INFORMATION

Name of Health Insurance Company	Company Address	Physician's Name
Policy/Group/Employee Number	HMO Number, if applicable	Physician's Telephone Number

MEDICAL INFORMATION

(Circle any current health condition that may require attention during your stay)

Allergies
- Foods ______________________________________
- Medicines ____________________________________
- Bee/insect sting ________________________________
- Other _______________________________________

Asthma
Cancer
Diabetes
Hearing problems – hearing aid(s)
Heart problems (be specific)
____

Hemophilia
Physical disability (be specific):
____
Respiratory (be specific):
____
Seizures
Vision problems (be specific): glasses contacts
____
Others (be specific):
____
____

List all medications and dosages you receive on a daily basis:

NCSS has my permission, in any emergency when my parent(s)/guardian or designated emergency contact cannot be contacted, to take me to the emergency room of the nearest hospital, and the hospital and its medical staff have my authorization to provide treatment which a physician deems necessary for my well-being.

Signature Date