Dale Rogers Training Center

Intake/Emergency Information Form

Today's Date:_____

Name of person completing form:_____

Home Phone Number: (___)_____ Cell Phone Number: (___)_____

Please fill out every blank with information or "n/a"

Individual Information

Name:_____

Last First MI

Social Security Number:_____

Birth Date:_____ Application Date:_____

Current Address:_____ Home Phone # : (___)_____

_____ Cell Phone # : (___)_____

Email address:_____

Emergency Contact/Family/Guardian/Caregiver Information

Primary Emergency Contact Name:_____ Contact Phone: (___)_____

Address:_____

Number City State Zip Code

Legal Guardian? ❑ Yes ❑ No

Contact Employer: _____ Employer Phone: (___)_____ext._____

Alternate Phone(s):_____ Email address:_____

Name of person/counselor who referred you:_____

Medical Information

Medical Card? ❑ Yes ❑ No Type of medical card:_____ Height:_____ Weight:_____

Emergency Contact Person Name:_____

Emergency Contact Phone: (___)_____ Emergency Contact Work Phone: (___)_____

Preferred Hospital:_____

Physician Name:_____ Physician Phone Number: (___)_____

Seizure Disorder? ❑ Yes ❑ No

If yes, explain in detail what they look like:_____

_____

Mobility/Physical Limitation(s):_____

Last Tetanus Shot (date):_____

Work Limitations:_____

Last Medical Exam:_____ Last Psychological Exam:_____

Current Medications (attach additional sheet if needed):

Name	Dose	How often?	Time Given	Reason	Side Effects

Personal Information

Individual's Permanent Address:_____

Individual's Permanent Phone: (___) _____

Gender: ❑ Male ❑ Female

Race: ❑ Asian ❑ Black ❑ Caucasian ❑ Hispanic ❑ American Indian

❑ Other:_____

Marital Status: ❑ Single ❑ Divorced ❑ Widowed ❑ Married - Spouse's Name:_____

Primary Language spoken in the household: ❑ English ❑ Spanish ❑ Vietnamese ❑ Sign Language

Other:_____

SSI Recipient? ❑ Yes ❑ No SSDI Recipient? ❑ Yes ❑ No

Primary Diagnoses:_____ Secondary Diagnoses:_____

Insurance Information

Insurance Name (if applicable):_____

Insurer Name:_____ Insurance Number:_____

LIST ANY OTHER MEDICAL CONDITIONS THAT MAY BE IMPORTANT IN CASE OF MEDICAL TREATMENT:

_____

_____

Additional Individual Information

Blood Type:_____ Eye Color:_____

Glasses/contacts? ❑ Yes ❑ No

Special diet/food restrictions? ❑ Yes ❑ No

Specifics/reason:_____

Has diabetes? ❑ Yes ❑ No

If yes, do you take: ❑ oral medication or ❑ injection

Wears hearing aids? ❑ Yes ❑ No

List any medication allergies:_____

List any other allergies:_____

Religion (optional): _____

Additional Emergency Contact Information:

Should we be unable to reach either the primary contact person or emergency contact person in case of emergency, please give name and phone number of two (2) **additional** people who will be able to help us reach you or who may be able to assist the individual in an EMERGENCY.

Name:_____ Home Phone:_____ Work Phone:_____

Relationship:_____ Alternate Phone(s):_____

Name:_____ Home Phone:_____ Work Phone:_____

Relationship:_____ Alternate Phone(s):_____

NOTE: Individuals taken to the hospital by ambulance are taken to the hospital deemed most appropriate by the Ambulance Emergency Medical Staff. Dale Rogers Training Center is not responsible for reimbursements for medical attention or any other type of compensation for emergency treatment **(except for Worker's Compensation cases)**.