RESPITE EMERGENCY INFORMATION

Name:______________________________ Date of Birth:__________________ Home Phone:_______________________

Home Address:____

Medicaid #:________________________DD Waiver Medicaid #:_______________________________

Parent/Guardian:___________________________________ Home Phone (if different)____________________________

Work Phone:_________________ Cell Phone:_________________ Other________________

Is your family member on Salud? ☐ Yes ☐ No If yes: ☐ Molina ☐ Presbyterian ☐ Lovelace

Does your family member have health insurance or a Health Maintenance plan (HMO)? ☐ Yes ☐No

Name of Health Insurance Company:____

Policy Number:____________________________________Group Number:______________________________________

Diagnosed Chronic Conditions:____

Primary Doctor:____Phone Number:_________________________

Hospital Preference:__________________________________Address:____

Dentist:____Phone Number:_________________________

Dentist's Address:____

Dental Insurance:____Policy Number:_________________________

MEDICATIONS	DOSAGE	TIMES TAKEN

Medications your family member is allergic to:____

Other allergies:____

Special Care Information:____

Immunization Status: ☐Current/Up to Date ☐Incomplete ☐No Immunizations

Emergency Contacts: If the Respite Provider cannot reach you, who should they contact? Provide at least 2 emergency contacts.

Name:__________________________	Name:__________________________	Name:__________________________
Home Phone:_____________________	Home Phone:_____________________	Home Phone:_____________________
Work Phone:_____________________	Work Phone:_____________________	Work Phone:_____________________
Cell Phone:_____________________	Cell Phone:_____________________	Cell Phone:_____________________
Pager:__________________________	Pager:__________________________	Pager:__________________________

Reviewed by Parent/Guardian: __________________________ Date:_____________

MEDICAL RELEASE

For

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In the event of an accident or sudden illness, and if I cannot be reached, I hereby authorize the Respite Provider, named, ___________________________, to obtain emergency medical or hospital care and/or transportation. I further agree to relieve the physician, hospital, Abrazos Family Support Services and the Respite Provider for the consequences of their actions while acting in good faith. It is also agreed that I will assume all financial liability for such emergency treatment.

____ ___________________________________

Signature of parent or guardian Date