

MEDICAL & CONTACT INFORMATION FORM

NAME: _____ DATE OF BIRTH: ____ / ____ / ____ GENDER: _____ M _____ F

ADDRESS: _____ CITY _____ ZIP _____ PHONE: (____) _____

PRIMARY CAREGIVER: _____ RELATIONSHIP: _____ PHONE: (____) _____

PRIMARY EMAIL: _____ SECONDARY EMAIL: _____

MOTHER'S NAME: _____ PHONE: (____) _____

ADDRESS (if different than above): _____ CITY _____ ZIP _____

FATHER'S NAME: _____ PHONE: (____) _____

ADDRESS (if different than above): _____ CITY _____ ZIP _____

ADDITIONAL EMERGENCY CONTACT NAME: _____ PHONE: (____) _____

DISABILITY: _____

VISUAL/HEARING CONCERNS (glasses, hearing aids, etc.): _____

ORTHOPEdic CONCERNS (braces, crutches, wheelchair, etc.): _____

SEIZURE? _____ YES _____ NO IF YES, WHAT TYPE? _____

ALLERGIES? _____ YES _____ NO IF YES, WHAT TYPE? _____

DESCRIPTION OF DRUG AND/OR ALLERGIC REACTIONS: _____

SIGNIFICANT ILLNESS/OPERATIONS: _____

SPECIAL NEEDS/COMMENTS (assistance w/ money, bathing, dressing, dietary needs, behavioral problems, sleep disturbances, etc.): _____

DOCTOR'S NAME: _____ PHONE: (____) _____

DOCTOR'S ADDRESS (or place of practice): _____

HEALTH INSURANCE CARRIER: _____ MEMBER NO.: _____

MEDICATION: _____ DOSAGE: _____ TIME(S) GIVEN: _____

MEDICATION: _____ DOSAGE: _____ TIME(S) GIVEN: _____

MEDICATION: _____ DOSAGE: _____ TIME(S) GIVEN: _____

This is my permission for above named to participate in ARCH activities. I will make certain he/she is in good health. I authorize ARCH Staff to dispense medication and secure medical treatment if necessary in the event of an emergency. I also waive all liability for any accident on the part of ARCH and/or Staff and will not hold ARCH responsible.

Signature: _____ Date: _____

I grant permission to ARCH to use the likeness, voice, and words of above in T.V., newspapers, film and other media for the purpose of communicating the activities of ARCH, and in appealing for funds to support such activities.

Signature: _____ Date: _____

NAME OF LEGAL GUARDIAN: _____ Phone No. _____

Race: (For government census purposes only)
 White Black/African American Hispanic American Indian/Alaskan Native Asian Other

Permission to leave ARCH Property/Supervisory Needs

I give permission for (participant's name) _____ to
leave ARCH property unsupervised for the following: (includes using City Bus)

Any purpose

Specific purposes: Please List: _____

I *do not* give permission for (participant's name) _____ to
leave ARCH premises unsupervised for ANY reason.

Additional Comments and/or Client needs/concerns (i.e., assistance/supervision needs in
bathroom, kitchen, to/from transportation, etc.): _____

Persons and/or Transportation Modes Authorized to pick-up participant:

Name: _____ (relation) _____
Name: _____ (relation) _____
Name: _____ (relation) _____

Dial-a-Ride

Reserve-a-Ride

Other (specify): _____

Please list name (s) of any individual that participant MAY NOT leave with under any
circumstances: _____

Is this individual allowed to visit participant on ARCH premises? Y _____ N _____

Procedure to follow? _____

Form Completed By:

Name (print) _____

Signature: _____ Date: _____

Relationship to Participant

Parent

Guardian

Self (own guardian)

Other (explain) _____