

**ST. JOHN'S COMMUNITY HAVEN EMERGENCY FILE CARD** DATE \_\_\_\_\_ CPR: YES NO

CLIENT'S NAME \_\_\_\_\_ BIRTH DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY, STATE, ZIP \_\_\_\_\_

FAMILY/GUARDIAN CLIENT LIVES WITH \_\_\_\_\_

HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ Ext \_\_\_\_\_

CAREGIVER'S EMPLOYER \_\_\_\_\_

**IF YOUR MAIN WORK NUMBER DEFERS TO VOICE MAIL, PLEASE LIST AN ALTERNATIVE NUMBER.  
If family/guardian cannot be reached, Community Haven will contact one of the following people on your list.  
(PLEASE DO NOT LIST VOICE MAIL)**

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ EVENING PHONE \_\_\_\_\_

DAY PHONE \_\_\_\_\_

NAME \_\_\_\_\_ RELATIONSHIP \_\_\_\_\_ EVENING PHONE \_\_\_\_\_

DAY PHONE \_\_\_\_\_

DAYS ATTENDING: MON TUES WED THURS FRI

DOCTOR'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

1ST HOSPITAL CHOICE \_\_\_\_\_ 2ND HOSPITAL CHOICE \_\_\_\_\_

INSURANCE NAME \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

MEDICARE NUMBER \_\_\_\_\_ MEDICAID NUMBER \_\_\_\_\_

(OVER)

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DOCTOR'S NAME \_\_\_\_\_ PHONE \_\_\_\_\_

1ST HOSPITAL CHOICE \_\_\_\_\_ 2ND HOSPITAL CHOICE \_\_\_\_\_

INSURANCE NAME \_\_\_\_\_ SOCIAL SECURITY NUMBER \_\_\_\_\_

MEDICARE NUMBER \_\_\_\_\_ MEDICAID NUMBER \_\_\_\_\_

(OVER)

MEDICATIONS: List all prescriptions and non-prescription taken regularly: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MEDICAL INFORMATION: List all health conditions Physical limitations, medical limitations/impairments, emotional or behavioral problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

CLIENT MAY BE GIVEN TYLENOL AS PRESCRIBED ON THE BOTTLE: YES NO  
ALLERGIES (FOOD & MEDICINES) \_\_\_\_\_  
\_\_\_\_\_

**EMERGENCY MEDICAL CARE**

This authorizes Community Haven to secure **EMERGENCY** medical care for myself/family member when I/we cannot be immediately reached at the time of emergency. I/we will be responsible for the emergency medical charges upon receipt of the statement.

Client/Family/Guardian Signature: \_\_\_\_\_

MEDICATIONS: List all prescriptions and non-prescription taken regularly: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

MEDICAL INFORMATION: List all health conditions Physical limitations, medical limitations/impairments, emotional or behavioral problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
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