Emergency Information for Children with Special Needs

First Name:	**Last Name:**	**Middle Name:**
Birth Date:	**Nick Name:**	**Home Phone(must be a landline):**
Address Information:		
House Number:	**Street:**	**Community:**
State:	**Zip Code:**	**Telephone Number(s)**
Parent or Guardian:		
Primary Language::		
Emergency Contact Names and Relationship:		
Phone Numbers:		
Communication Concerns:		

Health Concerns: (Please check all that apply)		
Allergies	☐ Yes	☐ No
Breathing Problems	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No
Seizures	☐ Yes	☐ No
Dietary Concerns	☐ Yes	☐ No
Heart Problems	☐ Yes	☐ No

Hearing Impairment	☐ Yes	☐ No
Vision Impairment	☐ Yes	☐ No
Other:	☐ Yes	☐ No

Special Considerations related to above conditions:

List special medical equipment needed for individual: (Ex.: suction machine, feeding pump, wheelchair, etc.):

Is electricity needed?: ☐ Yes ☐ No

Is there a Do Not Resuscitate Order(DNR) in place? ☐ Yes ☐ No

Is there a development delay or diagnosis? ☐ Yes ☐ No Please list (Ex.: autism, asperger's syndrome, cerebral palsy, down's syndrome, etc.)

Parent Signature:	Date: