EMERGENCY CONTACT FORM

To Be Completed for Every Client

Client Name: _____ **Date of Birth:** _____

Emergency Contacts

Please list contacts in the order they should be called in an emergency.

Priority	Name	Relationship	Phone (Primary)	Phone (Alternate)
1				
2				
3				

Primary Care Physician

Physician Name: _____ **Practice/Clinic Name:** _____

Phone Number: _____ **Address:** _____

Preferred Hospital

Hospital Name: _____ **Address:** _____

Insurance Information

Insurance Provider: _____ **Policy/Member ID:** _____

Medicaid/CMO Number (if applicable): _____

Known Allergies (Summary)

Full medical detail should be provided on the Medical and Behavioral Information Form. List critical, life-threatening allergies here for quick driver reference:

Critical Allergies: _____

Authorization for Emergency Care

If I cannot be reached during a medical emergency involving the Client, I authorize Covered Journey Transportation Co. staff to contact emergency medical services (911) and to share the information on this form and the Medical and Behavioral Information Form with first responders and treating medical personnel as necessary to ensure the Client's safety and care.

Parent/Guardian Signature	*Date*
Date	*Date*