GLOBAL HEALTHCARE SERVICES, LLC.
Joint Commission Accredited

EMERGENCY CONTACT FORM

CLIENT'S NAME _____ DOB _____

CLIENT'S PHONE NUMBER: _____SOC. SEC. # _____

GENDER _____ AGE _____ RACE _____ MA# _____
CLIENT'S TELEPHONE NUMBER: _____
CLIENT'S ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE _____
IS CLIENT ON MEDICATION □ **YES** □ **NO** IF YES, LIST MEDICATIONS
_____
_____
_____
_____
NAME OF PARENT OR GUARDIAN IF APPLICABLE: _____
ADDRESS: _____
CITY_____ STATE_____ ZIP CODE_____
TELEPHONE NUMBER _____
SPECIAL INSTRUCTIONS OR RESTRICTIONS_____

EMERGENCY CONTACTS

1. **NAME**_____ **RELATIONSHIP:** _____
   TELEPHONE # _____ **WORK #**_____
   ADRESS_____
   CITY_____ **STATE**_____ **ZIP CODE** _____
2. **NAME**_____ **RELATIONSHIP:** _____
   TELEPHONE # _____ **WORK #**_____
   ADRESS_____
   CITY_____ **STATE**_____ **ZIP CODE** _____
3. **NAME**_____ **RELATIONSHIP:** _____
   TELEPHONE # _____ **WORK #**_____
   ADRESS_____
   CITY_____ **STATE**_____ **ZIP CODE** _____

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

□ MEDICATION □ **YES** □ **NO** **IF YES, EXPLAIN** _____
□ FOOD □ **YES** □ **NO** **IF YES, EXPLAIN** _____
□ INSECTS/BUGS □ **YES** □ **NO** **IF YES, EXPLAIN** _____

CLIENT/PARENT OR GUARDIAN SIGNATURE: _____ **DATE**_____
GHC STAFF SIGNATURE _____**DATE:** _____

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