



EMERGENCY DATA SHEET

Participant Info	
Name:	
Address:	
Telephone Number:	
Date of Birth:	

Participant's Family or Legal Guardian Info			
Name:		Relation:	
Address:			
Telephone Number:			

Participant's diagnosis: _____

Medications administered to or by the participant at the facility: _____

Allergies: _____

Participant's functional level & needs requirements: _____

Participant's Health Insurance: CFI NH Healthy Families Well Sense Medicaid VA

If CFI, Who is Case Manager/Organization: _____

Participant's Health Insurance Number: _____

Participants Primary Care Physician: _____

Primary Care Physician's Info: Phone: (603) _____ Fax: (603) _____

Address: _____

Desired Days of Attendance: Monday Tuesday Wednesday Thursday Friday Saturday

Ambulatory Level: Walks With No Assistance Walker Wheelchair Confined To Bed

Is participant home alone at day while family works? Yes No

How many times has participant been to ER in past: 1 year: _____ 2 years: _____

Participant has: Advanced Directives Do Not Resuscitate Durable Powers of Attorney Living Will

Can Nashua Adult Day Health use pictures of you for social media, advertisements & promotions? Yes No

By signing below, I give consent to release medical information to necessary health care providers and insurance agencies. Details for HIPPA compliance can be found in the Policies and Procedures Manual.

Name: _____ **Signature:** _____

Date: _____