

DATE \_\_\_\_\_ **EMERGENCY CARD** SS# \_\_\_\_\_

NAME: \_\_\_\_\_ BIRTH DATE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

CITY/STATE/ZIP: \_\_\_\_\_

TO GUARDIAN: To serve your client in case of ACCIDENT OR SUDDEN ILLNESS, it is necessary that you furnish the following information for emergency calls;

Parent/Guardian	_____	_____	_____	_____
	Name/Relationship	Home Phone	Work Phone	Mobile/Cell Phone
Additional Contact	_____	_____	_____	_____
	Name/Relationship	Home Phone	Work Phone	Mobile/Cell Phone

**PRIMARY DIAGNOSIS:** \_\_\_\_\_

**OTHER DIAGNOSES (Include any other health conditions such as heart disease, diabetes, seizure disorder, eye/ear problems, or any chronic conditions, etc.) :** \_\_\_\_\_

**PLEASE LIST ALL ALLERGIES:** \_\_\_\_\_

**WE NEED A COMPLETE LIST OF YOUR MEDICATIONS:** \_\_\_\_\_

**WILL YOU BE GETTING ANY MEDICATION FROM REDWOOD: YES \_\_\_\_\_ NO \_\_\_\_\_**  
**IMPORTANT – PLEASE COMPLETE THE REVERSE SIDE OF THIS CARD**

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**WILL YOU BE GETTING ANY MEDICATION FROM REDWOOD: YES \_\_\_\_\_ NO \_\_\_\_\_**  
**IMPORTANT – PLEASE COMPLETE THE REVERSE SIDE OF THIS CARD**

DOCTOR: 1st Choice \_\_\_\_\_ 2nd Choice: \_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

HOSPITAL CHOICE \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

I, the undersigned, do hereby authorize personnel of Redwood Rehabilitation Center to contact directly the persons named on this card, and do authorize the named physicians to render such treatment as may be deemed necessary in an emergency for the care needed

In the event physicians, other persons named on this card, or parents cannot be contacted, the Redwood officials are hereby authorized to take whatever action is deemed necessary in their judgment, for the health of aforesaid person.

I will not hold Redwood Rehabilitation Center financially responsible for the emergency care and/or transportation needed.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Notary Public

\_\_\_\_\_  
Commission Expires

DOCTOR: 1st Choice \_\_\_\_\_ 2nd Choice: \_\_\_\_\_

Phone \_\_\_\_\_

Phone \_\_\_\_\_

HOSPITAL CHOICE \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

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