



# EMERGENCY FORM

## PERSONAL INFORMATION

NAME			DATE OF BIRTH
LAST	FIRST		
ADDRESS			PHONE
CITY	STATE	ZIP	VILLAGE

## PRIMARY EMERGENCY CONTACT

NO CHANGES     DECLINED TO STATE

CONTACT NAME	RELATIONSHIP	HOME PHONE	
ADDRESS		ALTERNATE PHONE	
CITY	STATE	ZIP	E-MAIL

## SECONDARY EMERGENCY CONTACT

NO CHANGES     DECLINED TO STATE

CONTACT NAME	RELATIONSHIP	HOME PHONE	
ADDRESS		ALTERNATE PHONE	
CITY	STATE	ZIP	E-MAIL

I AUTHORIZE CITY OF IRVINE STAFF TO CONTACT ABOVE PERSON FOR  
ADDITIONAL INFORMATION OR IN AN EMERGENCY.     YES     NO

\_\_\_\_\_  
SIGNATURE

### FOR OFFICE USE ONLY

C-1 REGISTRATION     C-2 REGISTRATION     OUTREACH    DATE COMPLETED     STAFF

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# EMERGENCY FORM

## DOCTOR INFORMATION

NO CHANGES     DECLINED TO STATE

PRIMARY PHYSICIAN

PHONE

CITY

STATE

ZIP

HOSPITAL/MEDICAL GROUP

INSURANCE COVERAGE

MEDICARE

MEDI-CAL

SENIOR HMO

OTHER \_\_\_\_\_

## MEDICAL INFORMATION

PROVIDE MEDICAL INFORMATION (Example: heart condition, arthritis, diabetes, disabilities, etc.)

MEDICATIONS		TREATMENT FOR	MEDICATIONS		TREATMENT FOR
1.	<input type="checkbox"/> NEW		5.	<input type="checkbox"/> NEW	
2.	<input type="checkbox"/> NEW		6.	<input type="checkbox"/> NEW	
3.	<input type="checkbox"/> NEW		7.	<input type="checkbox"/> NEW	
4.	<input type="checkbox"/> NEW		8.	<input type="checkbox"/> NEW	

ADVANCED HEALTH CARE DIRECTIVE

YES

NO