ASU SPEECH AND HEARING CENTER **A-4**
P.O. BOX 910 STATE UNIVERSITY, AR 72467-0910
PH. (870) 972-3301 FAX (870) 972-3788

EMERGENCY MEDICAL STATUS & PATIENT INFORMATION

Date completed:_____
Name:_____ Age:_____
Current Address: _____
Local Telephone #: _____

EMERGENCY CONTACT INFORMATION

Name (parent/significant other):_____
Address:_____
Home Ph #:_____Cell Ph #: _____Work Ph #:_____

EMERGENCY MEDICAL INFORMATION

Primary Care Physician:_____
Address:_____
Telephone #:_____

Medical Conditions (including allergies to prescription medications or other allergic conditions):
_____
_____

Current Prescription Medications:
_____
_____

Living will: yes no

In the event of an emergency situation, I understand that every effort will be made to communicate with the identified emergency contact individual. If the individual is not immediately available I understand that emergency services may be secured using 911 and that charges for such services are the responsibility of the client/parent/significant other.

_____
Client Name (please print)

_____ _____
Client Signature Date

_____ _____ _____
Witness Signature Date File #

PF Revised: 1/15/14