Emergency Contact Form

<u>Please notify the Chapter immediately if there are any changes to this information</u>

Form completed on (date) _____

Participant's Information

Participant's First Name _____ Last Name _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____

Primary Caregiver's Information

Caregiver's First Name _____ Last Name _____

Relationship to the participant _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact Information

******* Contacts must reside in WNY. Please notify persons listed on this form that they are listed as emergency contacts for a program participant at the Alzheimer's Association.

Emergency Contact #1 <u>(other than the caregiver listed above)</u>

Name _____ Relationship _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact #2 <u>(other than the caregiver listed above)</u>

Name _____ Relationship _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Medical History

Chronic Illnesses and Diagnoses

☐ Please list: _____

☐ None

Current Medications

☐ Please list: _____

☐ None

Allergies (include food & drug allergies)

☐ Please list: _____

☐ None

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