



Dedicated to offering quality life style choices  
to teens and adults with disabilities.

### Emergency Contact and Medical Information

Participant's Name _____		Date of Birth _____		M	F
				Sex	
Parent's/Guardian's Name _____		Parent's/Guardian's Name _____			
( ) _____	( ) _____	( ) _____	( ) _____		
Home Phone	Work Phone	Home Phone	Work Phone		
Address _____		Address _____			
City, ST ZIP Code _____		City, ST ZIP Code _____			

### Alternative Emergency Contacts

Primary Emergency Contact _____		Secondary Emergency Contact _____	
( ) _____	( ) _____	( ) _____	( ) _____
Home Phone	Work Phone	Home Phone	Work Phone

### Medical Information

Hospital/Clinic Preference \_\_\_\_\_

Physician's Name _____	Phone Number _____
Insurance Company _____	Policy Number _____

Primary Diagnosis/Special Health Conditions \_\_\_\_\_

Current Medications and Dosage \_\_\_\_\_

I authorize all medical and surgical treatment, X-ray, laboratory, anesthesia, and other medical and/or hospital procedures as may be performed or prescribed by the attending physician and/or paramedics for my child and waive my right to informed consent of treatment. This waiver applies only in the event that neither parent/guardian can be reached in the case of an emergency.

Parent's/Guardian's Signature _____	Date _____
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