VANTAGE Workforce Solutions
Formerly Mature Services

Senior Community Service Employment Program

Emergency Medical Information

Name of PARTICIPANT			
Street Address:			
City:		**State:**	**Zip:**
Telephone: ( ) -	**Age:**	**Date of Birth: / /**	
Please provide us with the names of PEOPLE TO CONTACT in case of an emergency.			
First Choice:			
Name:		**Relationship:**	
Street Address:			
City:		**State:**	**Zip:**
Telephone (home): ( ) -	**(work): ( ) - , ext.**		
Second Choice:			
Name:		**Relationship:**	
Street Address:			
City:		**State:**	**Zip:**
Telephone (home): ( ) -	**(work): ( ) - , ext.**		
Please describe any MEDICAL CONDITION that should be reported to paramedics in the event of any medical emergency (include any algeries).			
Are you taking any MEDICATIONS? ☐ ***Yes ;*** ☐ ***No***			
If YES, please list name, dosage, and how often you take each medication.			
1.	**2.**	**3.**	
4.	**5.**	**6.**	
7.	**8.**	**9.**	
10.	**11.**	**12.**	
Your Doctor's Name:		**Phone #: ( ) -**	
Hospital Preference:			
Ambulance Preference:			
I give permission for this information to be used by emergency practitioners in the event that I experience an emergency.			
		/ /	
Participant Signature		**Date Signed**	

Revised 1/1/2018