Developing Potential, Inc. Independence, Kansas City, or Lee's Summit Site
Emergency Data File Identification Information

Name: ____

Address: __________________________ City/State/ZIP: __________________County:__________

Phone Number: ____________________ Birth Date: ___________ Sex: ______ Race: ____________

Disability/Diagnosis: ____

Transportation provided by: ______________________Transportation Phone Number: ______________

Height: __________________ Weight: _______________________ Hair Color: _______________

Email address: ____

IN AN EMERGENCY, PLEASE NOTIFY THE FOLLOWING PEOPLE:

1. Name ________________________________ Relationship: _____________________________
Home # ___________________ Work # ____________________Cell # ______________________
2. Name ________________________________ Relationship: _____________________________
Home # ___________________ Work # ____________________Cell # ______________________
3. Name ________________________________ Relationship: _____________________________
Home # ___________________ Work # ____________________Cell # ______________________

Guardian:_______________________________ Phone #: _________________________________
Guardian Address: ________________________ City, State, Zip: ___________________________
Guardian email address:____
**(Proof of guardianship is required)*
Hospital preference: ______________________ Location: _________________________________
Primary Physician: _______________________ Phone Number: ___________________________
Health Insurance: _________________________ Policy # _________________________________
Medicaid # _____________________________ Medicare # ______________________________

Current Medications (include ALL meds, not just meds given at DPI):

Name:	Dosage:	Time:	Reason for Med:

Is the person subject to seizures? Yes / No If yes, special instructions? ______________________
____
Special health or physical problems: ____
____
Medication and /or treatments to avoid: ____
____
Allergies: *(If none known please state 'NKA' None Known Allergies):* ________________________
Special Restrictions or Assistive Technology Used: _____________________________________

Signature of person filling out this form: ______________________________Date: _________
Relation to person served:____

3-17KW_3-18KW_3-19KW