COMMUNITY SERVICES
Senior Services

Print Form

EMERGENCY FORM

PERSONAL INFORMATION

NAME		DATE OF BIRTH
LAST	FIRST	
ADDRESS		PHONE

CITY	STATE	ZIP	VILLAGE

PRIMARY EMERGENCY CONTACT

☐ NO CHANGES ☐ DECLINED TO STATE

CONTACT NAME	RELATIONSHIP	HOME PHONE
ADDRESS		ALTERNATE PHONE

CITY	STATE	ZIP	E-MAIL

SECONDARY EMERGENCY CONTACT

☐ NO CHANGES ☐ DECLINED TO STATE

CONTACT NAME	RELATIONSHIP	HOME PHONE
ADDRESS		ALTERNATE PHONE

CITY	STATE	ZIP	E-MAIL

I AUTHORIZE CITY OF IRVINE STAFF TO CONTACT ABOVE PERSON FOR ADDITIONAL INFORMATION OR IN AN EMERGENCY. ☐ YES ☐ NO

SIGNATURE

FOR OFFICE USE ONLY

☐ C-1 REGISTRATION ☐ C-2 REGISTRATION ☐ OUTREACH DATE COMPLETED STAFF

EMERGENCY FORM

DOCTOR INFORMATION

☐ NO CHANGES ☐ DECLINED TO STATE

PRIMARY PHYSICIAN			PHONE
CITY	STATE	ZIP	HOSPITAL/MEDICAL GROUP

INSURANCE COVERAGE

☐ MEDICARE ☐ MEDI-CAL ☐ SENIOR HMO ☐ OTHER _____

MEDICAL INFORMATION

PROVIDE MEDICAL INFORMATION (Example: heart condition, arthritis, diabetes, disabilities, etc.)

MEDICATIONS		TREATMENT FOR	MEDICATIONS		TREATMENT FOR
1.	☐ NEW		5.	☐ NEW	
2.	☐ NEW		6.	☐ NEW	
3.	☐ NEW		7.	☐ NEW	
4.	☐ NEW		8.	☐ NEW	

ADVANCED HEALTH CARE DIRECTIVE

☐ YES ☐ NO