



St. Lawrence
College

Centre for Behavioural Studies

Emergency Information and Contacts

Name: _____	Nickname: _____
DOB: _____	Height: _____
	Weight: _____
Diagnosis: _____	
Allergies: _____	
Pre-Existing Conditions: _____	
Other Medical Concerns: _____	
Medications (name, dose and times): _____	
How does this person respond in stressful situations? _____	
How is this person best supported in stressful situations? _____	

Primary Emergency Contacts:

Caregiver's Name: _____ Home Phone: _____ Daytime Phone: _____ Cell Phone: _____ Email: _____	Home Address: _____ _____ _____
Caregiver's Name: _____ Home Phone: _____ Daytime Phone: _____ Cell Phone: _____ Email: _____	Please complete if person lives at a residential facility: Name of Facility: _____ Contact: _____ Phone: _____
Doctor's Name: _____ Office Phone: _____	

Additional Emergency Contacts:

Name: _____	Phone: _____
Address: _____	Relation: _____
Name: _____	Phone: _____
Address: _____	Relation: _____

I give my permission for the following people to pick _____ up from the Centre for Behavioural Studies:

1. Name: _____	Phone: _____	Relation: _____
2. Name: _____	Phone: _____	Relation: _____
3. Name: _____	Phone: _____	Relation: _____

Signature of Legal Guardian

Date

Signature of Witness

Date