

City of Easthampton

Council on Aging

Date: \_\_\_\_\_

**EMERGENCY CONTACT FORM**

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone #: \_\_\_\_\_ ? Live Alone: \_\_\_\_\_

Medical History: \_\_\_\_\_

**Emergency Contact**

Please list 2 people (relatives, friends, neighbors) we can contact in case of emergency.

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone #: \_\_\_\_\_

Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

**Physical Limitations: (impaired mobility, medical device, oxygen, etc.)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Location of Entry:  Front Door  Side Door  Other \_\_\_\_\_

Name/Telephone # Medical Doctor(s): \_\_\_\_\_

Other Comments \_\_\_\_\_