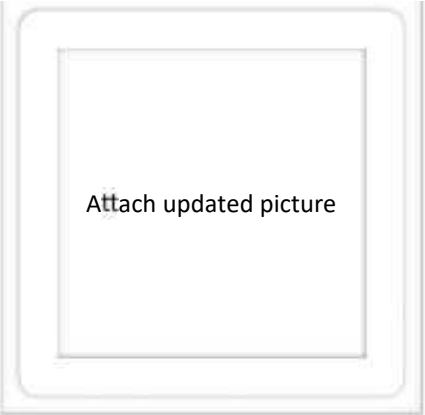
Special Needs Emergency Information Form

Sensory Friends
Think Sensitivity. Believe in #Inclusion



My name is: _____

My nickname is:_____ DOB: _____

My street address is: _____

_____Apt #_____

City:_____ State: _____

Zip code:_____ Primary Language:_____

I have a condition called:_____

Important things to know about me:

I communicate with: ☐ single words ☐ small sentences ☐ pictures

☐ Hand-leading ☐ typing ☐ writing ☐ device ☐ Other:_____

I am frightened by: ☐ yelling ☐ loud noises ☐ strangers ☐ crowds

☐ Being touched ☐ Other: _____

I don't like it when: _____

_____.

It would really be helpful if you would:_____

_____.

Emergency Contact(s):

Name 1: _____ Phone #: _____

Address: _____

Relationship: _____ Work #: _____

Name 2: _____ Phone #: _____

Relationship: _____ Work #: _____

Other Medical Information:

Insurance Plan: _____ Card #_____

Blood Type: _____ Primary Doctor: _____ Tel: _____

Medications:_____.

Allergies: _____.