(EOR Name) Medical Emergency Action Plan

Name:			Plan Effective Date:
Record #:		Medicaid #:	
Date of Birth:	Weight:	Height:	Guardianship Status:
Emergency Contact:			Relation:
Phone:	Email:		
Emergency Contact:			Relation:
Phone:	Email:		
Primary Care:			Phone:
Neurologist:			Phone:
Other Physician:			Phone:
Medications:			
Allergies:			
Significant Medical History:			

1. Call 911
2. Provide the following information:
    a. Nature of medical emergency
    b. Location of the emergency (address, building, room number)
    c. Your name and phone number from which you are calling.
3. Do not move the individual unless absolutely necessary for safety.
4. Perform CPR as required to assist prior to the arrival of the professional medical help.
5. Provide First Aid in an attempt to provide the following assistance:
    a. Stop the bleeding with firm pressure on the wounds (note: avoid contact with blood or other bodily fluids).
    a. Clear the air passages using the Heimlich Maneuver in case of choking.
6. In case of rendering assistance to personnel exposed to hazardous materials, call poison control and wear the appropriate personal protective equipment.
7. Call LRP and EOR

I have read this action plan and agree with the information. I also give permission for . . EOR Staff to seek emergency medical treatment and discuss said medical treatment with members of his/her medical team.

Individual Signature: _____ Date: _ ___

LRP/Parent/Guardian Signature: _____ Date: _____ ___

EOR/Representative Signature: _____ Date: _____