Via De Cristo Health Care Sheet

Participant's Name - Last, First

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Sponsor's Name - Last, First

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Emergency Contact Information:

Name - Last, First	Address	Phone1	Phone2
		( )________	( )________

Doctor

Name - Last, First	Phone	Emergency Phone
	( )________	( )________

Medical Concerns - Please attach additional sheets as necessary.

Do you need to be reminded when to take medication?

Do you have any special equipment needs? **(Wheelchair, Apnea machine, etc...)**

Food Allergies:	Type of reaction:	Typical Treatment

Other Allergies:	Type of reaction:	Typical Treatment

Do you have any Doctor ordered dietary restrictions? **If yes please explain**

Do you need snacks at specific times? **Please Indicate snack types & times**

Are there any other health needs? **Please attach additional sheets as necessary**

Do you require large print? **Yes No**