Autism Safety Project

www.autismsafetyproject.org

Emergency Information for Individuals with Autism Spectrum Disorder

PERSONAL INFORMATION	
Legal Name	
Nickname	
Sibling(s) Names	
Parent/Guardian	
Signature Consent*	
Address City State Zip	
Home Phone	
Mobile Phone	
Work Phone	
Pager Number	
PHYSICAL DESCRIPTION	
Date of Birth/Age/Gender Male ❑ Female ❑	
Height	
Weight	
Eye Color	
Hair Color	
Scars: Identifying Marks	
Photo Date (attach to back)	
MEDICAL INFORMATION	
Diagnosis	
Medical Diagnosis	
Special Diet Diet Restrictions	
Medications (list) Name Dose When	
Medication Allergies Yes ❑ No ❑	
Allergies Yes ❑ No ❑ Food ❑	
Health Insurance Plan Policy	
Pharmacy Name Phone	

*Consent for release of this form to Emergency Responders

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PHYSICIANS	
Primary Care Physician	
Primary Care Physician Phone	
Specialist	
Specialist Phone	
EMERGENCY CONTACTS	
1. Name	
Address City State Zip	
Home Phone	
Mobile Phone	
Work Phone	
Relationship	
2. Name	
Address City State Zip	
Home phone	
Mobile phone	
Work phone	
Relationship	
3. Name	
Address City State Zip	
Home Phone	
Mobile Phone	
Work Phone	
Relationship	
ADDITIONAL INFORMATION ABOUT THE INDIVIDUAL	
Common Presenting Problems	Photo
Things to Avoid	
Favorite Places	

Date form completed:
By Whom:
Relationship:

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