



MEDICAL RESPONSE PLAN

Effective Date: _____ **Review/Termination Date:** _____

Applicant Name: _____ **Student ID#:** _____
Last First MI

Residence Building: _____ **Room** _____ **Telephone:** _____

Home Address: _____ **Home Phone:** _____

INSTRUCTIONS SPECIFIC TO MY MEDICAL CONDITION:

1. Type of Medical Disorder _____
2. Medications taken: _____
3. Medication location: _____

4. **Symptoms/Manifestations:**

Mild/Moderate:	Severe/Emergency Level:
Response:	"Ecmn"Rctc o gfkeu "Vtcurqtv"vq"o gti gpe{"tqq o "Qvjgt" _____

5. Preferred local j qurkvcn"kh"pggfgf<"aa
6. Friend to call _____
Name Rjqpg
7. Family to notify _____
Name Rjqpg

K"ikxg" o {"rgtokuukqp"vq"tgngcug"vjg"kpht o cvkqp"rtqxkfgf"cdqxx"vq"Oguukj"Wpkxgtukv{ Department of Safety, Tgukfgpeg"Nkhg."Gping"Egpygt."cpf"hcwv{"kp"y jqug"encuugu"K"co"tgikuvgtgf0"K"wpfgtuvcpf"vcv"ogti gpe{"ogfkecn" assistance ma{"dg"uw o oqpgf"d{"Oguukj"Wpkxgtukv{ personnel cpf"ci tgg"vq"dg"hwnn{"tgurqpukdng"ht"vjg"equv"qh"uwej" assistance. **I am aware that I may refuse emergency medical assistance after it has arrived.** K"tgngcug"Oguukj" Wpkxgtukv{."kvu"g o rnk{ggg."qhhkegt"cpf"vtwuvvggu."htq o "cm"nkcdknkv{"hqt"klwt{"qt"nquu"y jkej"K" o c{"uwhtgt"cu"c"tguwnv"qh" o {" jgcnvj"eqpfkvkqp.

Signature of Applicant _____ Date _____

Signature of Parent (if applicant is under 18) _____

Distribution:

Applicant	Dept of Safety	Disability Services	Residence Director
Gping"Egpygt	Residence Life	G o gti gpe{"Flurcvej	

