

GRCC Medical Response Request

If you have specific requests for the GRCC Police Department in response to a known medical condition please complete this form and email it to police@grcc.edu or drop it off to our office at 25 Lyon St. NE. Everything you provide is voluntary.

If you need specific academic or campus accommodations please contact Disability Support Services at (616) 234-4140.

Please be aware, members of the GRCC Police Department will attempt to honor the requests listed on this document, however, in an effort to protect all individuals and the campus community, normal medical protocols may be followed if the individual is unable to communicate their needs, including calling for advanced emergency medical services. The final decision about transporting via ambulance to an area hospital is the responsibility of the EMS crew, based on their medical evaluation, and consent from the individual if they are able to communicate.

Personal Information

Name (first, middle, last): _____

Date of birth: _____ Student/Employee number: _____

Address: _____

Phone: _____

Medical Information

Type of medical condition: _____

Frequency of episodes: _____

What happens: _____

Type of medical condition: _____

Frequency of episodes: _____

What happens: _____

Type of medical condition: _____

Frequency of episodes: _____

What happens: _____

How would you like us to respond?

Seizure – Stay calm, begin timing seizures, keep me safe
by removing harmful objects, turn on side,
keep airway and mouth clear.

Provide first aid.

Notify emergency contact (provide information on next page).

Call 911 for transport to _____.

Other: _____.

When we will call 911

- Seizure with loss of consciousness longer than 5 minutes, not responding to rescue med if available
- Repeated seizures longer than 10 minutes, no recovery between them, not responding to rescue med if available
- Difficulty breathing after seizure
- Serious injury occurs or suspected
- Seizure/loss of consciousness in water

Additional Care Needed

What type of help is needed? (describe) _____

When is person able to resume usual activity? _____

Emergency Contacts

Name: _____ Phone: _____

Address: _____ Relationship: _____

Name: _____ Phone: _____

Address: _____ Relationship: _____

Medical Provider

Name: _____ Phone: _____

Address: _____

Special Instructions

First Responders:

Daily Medication

Name of medication	Size of dose	How many times per day and when	Total daily amount

Triggers:

Important medical history:

Allergies:

Signature: _____ Date: _____

This form will be on file for one year from the date signed. Please complete annually.