Employee Emergency Information & Contact Form

This medical information may be necessary in the event of serious illness or accident. Please complete this form accurately and truthfully. The facts you disclose will be kept confidential and the information provided will be given to others **only** in an emergency situation. ***Please return this form to the Human Resources Department.***

Employee Information			
Employee Name		Street Address	
City		State & Zip	
Social Security #		Date of Birth	
Phone #		Cell#	
School		Position	

Please list a person(s) to contact in case of an emergency:

Primary Contact Person:

Name _____ Relationship to that person _____

Cell #: _____ Work Phone #: _____

Secondary Contact Person:

Name _____ Relationship to that person _____

Cell #: _____ Work Phone #: _____

Preferred Medical Treatment Person/Location (HR Use Only):

Preferred Doctor _____ Office #: _____

Preferred Dentist _____ Office #: _____

Preferred Hospital _____ Office #: _____

Do you give permission for another doctor or dentist to treat you if preferred doctor is not available?

Yes No

Employee Emergency Contact and Medical Form:

Continued
(For HR Use Only)

Employee's Name _____ Position _____

Comments *(include any special medical or personal information you would want an Emergency care provider to know – or special information:*

Allergies:

Allergies to Medication:

Medication currently taken:

Other Information for the use of a Doctor or Nurse:

Do you give us permission to transport you to the nearest medical facility should you incur serious illness or injury during normal work hours?

Yes No

Employee's Signature _____ Date: _____

Please return this form to the Human Resources Department.