Optional Employee Emergency Information

This information may be extremely important in the event of an accident or medical emergency.

Employee Name: _____
Last First MI

Phone:
Home: _____ Cell: _____ Work: _____

Address: _____
Street City State Zip Code

Spouse Name: _____
Last First MI

Phone:
Home: _____ Cell: _____ Work: _____

Family Physician: _____ Phone: _____

Relevant Medical Conditions: _____

Current Medications:

Allergies:
Medications: _____

Food: _____

Other: _____

Please add any information you feel may help health care professionals in a situation where you may not be capable of communicating with them:

_____

May we share medical information with your supervisor? Doing so may help emergency response personnel. ☐ *Yes* ☐ *No*

Date Submitted: _____

Optional Dependent Emergency Information

Childs Name: _____
Last First MI
School: _____ Phone: _____

Childs Name: _____
Last First MI
School: _____ Phone: _____

Childs Name: _____
Last First MI
School: _____ Phone: _____

Childs Name: _____
Last First MI
School: _____ Phone: _____

Please add any additional information you feel necessary here:

Date Submitted: _____