EMPLOYEE EMERGENCY MEDICAL FORM

It is the responsibility of the employee to inform the administration of any changes or additions to this emergency medical form.

I. GENERAL INFORMATION

Employee Name:	Birth date	Gender ☐ M ☐ F	Home Phone
Address	City State		Zip Code

IN CASE OF EMERGENCY PLEASE CONTACT:

Name	Relationship	
Home phone:	Work phone:	Cellular phone
Name	Relationship	
Home phone:	Work phone:	Cellular phone
Preferred Hospital:		
Physicians Name Phone	Specialist Name Phone	Dentist Name Phone

List all current medications you are taking (prescription and over-the-counter). If necessary, include reason for taking medication.

List allergies to medicine, food or other allergens, and any medical information such as physical impairments and assistive devices, that emergency personal need to be aware of, attach documentation if necessary.

II. SIGNATURE AND CONSENT FOR EMERGENCY MEDICAL TREATMENT

Employee signature	Date Signed