District/Charter:

EMPLOYEE MEDICAL EMERGENCY INFORMATION

Name: (Last) ________________________(First)___________________(MI) ____ Last 4 of Social Sec No: _______________

Address:____(City)____________________(Zip)_____________

Home Telephone______________________ Date of Birth:____________ Sex: ☐M ☐F Marital Status: ☐M ☐S

Spouse's Name: __________________________________

In the event of a medical emergency please notify:

1. ____
Name Relationship

____
Address

____
Home Phone Business Phone

2. ____
Name Relationship

____
Address

____
Home Phone Business Phone

Doctor's Information:

1. ____
Name

____
Address

____
Phone

2. ____
Name

____
Address

____
Phone

Optional Information: (In the event of an emergency this information will be helpful.)

Do you have any physical conditions that would be significant in a medical emergency such as: Heart trouble, diabetes, epilepsy, hypertension, contact lenses, false teeth, pacemaker, etc.? If yes, please note:

____

Current prescribed medication, dosages and corresponding diagnosis: ____

Allergies to Medication: ____

Other Allergies: ____

Blood Type: ___________________ Religious Preference:_____________________ Hospital Preference: _________________

Medical Insurance Coverage, other than that provided by the District:

____
Insurance Carrier Subscriber Identification Number Group Number

I understand that the District assumes no financial responsibility for medical care or ambulance cost.

____ _________________________________
Employee Signature Date