

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

2. _____
Name Relationship

_____ Address

_____ Address

_____ Home Phone Business Phone

_____ Home Phone Business Phone

Doctor's Information:

1. _____
Name

2. _____
Name

_____ Address

_____ Address

_____ Phone

_____ 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