Staff Medical Emergency Information

Name: _____ **Date:** _____

Home Address: _____ **Phone:** _____

_____ **Cell:** _____

Spouse/Contact Person: _____ **Phone:** _____

Cell: _____

In the event that the above appropriate contact is not available, please list two other sources:

Name: _____ **Phone:** _____

Relationship: _____

Name: _____ **Phone:** _____

Relationship: _____

Medical Information

Allergies: _____

Medical Allergies: _____

Special Instructions: _____

Medical Conditions: _____

☐ **Contacts** ☐ **Glasses** ☐ **Dental Work:** _____

Physician: _____ **Phone:** _____

Address: _____

Preferred Hospital: _____

Dentist: _____ **Phone:** _____

Address: _____

Insurance

Company: _____ **Policy #:** _____

Additional Insurance: _____ **Policy #:** _____

Signature: _____ **Date:** _____