

### 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:** \_\_\_\_\_