

**STAFF EMERGENCY INFORMATION FORM**

\* Fields are required. All other fields are optional.

**\*Staff Information:**

\*Staff Name: \_\_\_\_\_

\*Date of Birth: \_\_\_\_\_

\*Address: \_\_\_\_\_

\*Primary Phone #: (    ) \_\_\_\_\_

\*Secondary Phone #: (    ) \_\_\_\_\_

Preferred E-mail Address: \_\_\_\_\_

\*School/Job Location: \_\_\_\_\_

Room # or Department (if applicable): \_\_\_\_\_

**\*Medical Information**

Allergies: \_\_\_\_\_

Medical Problems: \_\_\_\_\_

Physician: \_\_\_\_\_ Phone# \_\_\_\_\_

Dentist: \_\_\_\_\_ Phone# \_\_\_\_\_

Preferred Hospital: \_\_\_\_\_ Phone# \_\_\_\_\_

Remarks/Comments: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**\*\*\*\*Please Complete Reverse Side of Form for Emergency Contact Information**

**\*Primary Emergency Contact**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Phone #: (        ) \_\_\_\_\_

Secondary Phone #: (        ) \_\_\_\_\_

Employer: \_\_\_\_\_

Preferred Email: \_\_\_\_\_

**Additional Emergency Contacts**

(Optional in the event primary contact cannot be reached)

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Phone #: (        ) \_\_\_\_\_

Secondary Phone #: (        ) \_\_\_\_\_

Employer: \_\_\_\_\_

Preferred Email: \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_

Primary Phone #: (        ) \_\_\_\_\_

Secondary Phone #: (        ) \_\_\_\_\_

Employer: \_\_\_\_\_

Preferred Email: \_\_\_\_\_

\*Signature of Staff member: \_\_\_\_\_ \*Date: \_\_\_\_\_