

Staff Emergency Contact Form

Name: _____

Address: _____

Birthdate: _____

Home Telephone Number: _____

Parent (Guardian)/Spouse: _____

Address: _____

Home Telephone Number: _____

Business Name: _____

Address: _____

Business Telephone Number: _____

Emergency Contact Persons:

Name: _____

Telephone Number: _____

Name: _____

Telephone Number: _____

Name Physician/Medical Care Provider:

Address: _____

Telephone Number: _____

Special Disabilities: _____

Allergies: _____

Medical or Dietary Information Necessary in an Emergency Situation:

Medication/Special Conditions: _____

Additional Information on Special Needs: _____

Health Insurance Coverage or Medical Insurance Benefits:

Policy Number (Required): _____

Signature of Staff Member: _____

Date: _____