SAMPLE FORM

EMERGENCY INFORMATION ON STAFF

To be completed and placed on file prior to employment

NAME ____ ______________________________________

ADDRESS ____ ______________________________________

NAME OF DOCTOR ____ PHONE ______________________________

HOSPITAL PREFERENCE ____ PHONE ______________________________

NAME OF DENTIST ____ PHONE ______________________________

To avoid any adverse drug reaction during an emergency, please list medications you are taking: ___________________________

____ ______________________________________

ALLERGIES ____ ______________________________________

BLOOD TYPE (if known) ____ ______________________________________

LIST OPERATIONS/HOSPITALIZATIONS WITHIN THE PAST YEAR______

____ ______________________________________

LIST CHRONIC MEDICAL PROBLEMS REQUIRING A DOCTOR'S CARE ___

____ ______________________________________

EMERGENCY CONTACT PERSONS

NAME ____ RELATIONSHIP _________________________

ADDRESS ____ ______________________________________

HOME PHONE ____ BUSINESS PHONE _______________________

NAME ____ RELATIONSHIP _________________________

ADDRESS ____ ______________________________________

HOME PHONE ____ BUSINESS PHONE _______________________