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__________________