ESSEX FELLS SCHOOL

STAFF EMERGENCY FORM

Name_____ Date of Birth:_____

Address:_____

Home Phone:_____ Cell Phone:_____

I wear glasses - ☐ Yes ☐ No I wear contact lenses - ☐ Yes ☐ No

Allergies I have:_____

Medications I take:_____

When medication is taken:_____

Special instructions for medication:_____

_____ Date of last Tetanus Booster:_____

Physician name: _____ Phone:_____

Address:_____

Person(s) to be notified in case of illness or accident:

(1)
Name:_____ Relationship_____

Phone Numbers:

Home:_____ Work:_____ Cell:_____

(2)
Name:_____ Relationship_____

Phone Numbers:

Home:_____ Work:_____ Cell_____

Hospital of choice:_____ Location:_____

Special requests or additional pertinent information: _____

_____

In case of injury or illness, I hereby authorize the school to call the emergency names indicated and follow his/her instructions. If contact with my emergency names is impossible, the school may call my physician and follow his/her instructions.

Employee Signature:_____ Date:_____