

ST. ANDREW-ST. ELIZABETH ANN SETON CATHOLIC SCHOOL
EMPLOYEE EMERGENCY MEDICAL FORM



PERSONAL CONTACT INFORMATION

| | |
|--------------|--------------|
| NAME | JOB TITLE |
| ADDRESS | CITY |
| STATE | ZIP |
| HOME PHONE # | CELL PHONE # |

EMERGENCY CONTACT (1)

| | | |
|--------------|--------------|--------------|
| NAME | RELATIONSHIP | |
| ADDRESS | CITY | |
| STATE | ZIP | |
| HOME PHONE # | WORK PHONE # | CELL PHONE # |

EMERGENCY CONTACT (2)

| | | |
|--------------|--------------|--------------|
| NAME | RELATIONSHIP | |
| ADDRESS | CITY | |
| STATE | ZIP | |
| HOME PHONE # | WORK PHONE # | CELL PHONE # |

MEDICAL CONTACT

| | |
|--------------------|---------|
| DOCTOR NAME | PHONE # |
| DENTIST NAME | PHONE # |
| PREFERRED HOSPITAL | |

MEDICAL INFORMATION (VOLUNTARY)

| |
|--|
| ALLERGIES |
| CURRENT MEDICATIONS |
| MEDICAL CONDITIONS/CONCERNS (PLEASE LIST ANY HEALTH CONSIDERATIONS OR INFORMATION YOU WOULD LIKE EMERGENCY CARE PROVIDER TO KNOW.) |

- I have voluntarily provided the above contact information and authorize St. Andre-St. Elizabeth Ann Seton and its representatives to contact any of the above on my behalf in the event of an emergency.
- I choose **not** to furnish any emergency contact information to St. Andrew-St. Elizabeth Ann Seton at this time.

| | |
|---------------------------|-------------|
| EMPLOYEE SIGNATURE | DATE |
|---------------------------|-------------|