Emergency Contact Form

EMPLOYEE INFORMATION

Employee Name: _____

Address:
_____

Phone Numbers:

Work: _____

Home: _____

Cellular: _____

E-mail: _____

IN CASE OF AN EMERGENCY

Primary contact Name: _____

Relationship: _____

Address: _____

PHONE NUMBERS:

Work: _____

Home: _____

Cellular: _____

Secondary contact Name: _____

Relationship: _____

Address: _____

PHONE NUMBERS:

Work: _____

Home: _____

Cellular: _____

Physician's information:

Primary Care Physician's Name: _____

Phone number: _____

ADDITIONAL INFORMATION THAT MAY BE HELPFUL IN THE EVENT OF AN EMERGENCY:

ALLERGIES TO MEDICATION? YES or NO

Which Medications?_____

LATEX ALLERGY? YES or NO

IODINE ALLERGY? YES or NO

OTHER INFO: