EMPLOYEE EMERGENCY INFORMATION

(PLEASE PRINT)

EMPLOYER Circle One: Parish, School or Agency	SITE: CITY:

First Name Middle Name Last Name

Street Address City State Zip

_(_____)_____ _(_____)_____

Home Phone Number Cell Phone Number

Color, Make and Model of Vehicle License Plate Number State

Person to Contact in case of emergency:

Would you like us to contact this person if you are arrested or detained while at work: ☐ Yes ☐ No

Name Relationship

_(_____)_____ _(_____)_____

Daytime Phone Number Cell Phone Number

In the event you are unable to communicate at the time of an emergency while at work, please provide any information you would like to have provided to emergency medical personnel. Any information you provide will be maintained as confidential, separate from your personnel file, and will be referred to only in case of an emergency.

By providing the following information and signing below, you are authorizing a supervisor to disclose this medical information to emergency medical personnel as necessary to administer emergency treatment to you.

Allergic reactions to:

Current Medications:

Other Information: _____

To list more allergies, medications or concerns you may use the back of this form.
REMEMBER TO KEEP THIS FORM UPDATED.

Signature of Employee **Date**