WORCESTER COUNTY PUBLIC SCHOOLS
STAFF EMERGENCY FORM

EMPLOYEE

Name: ____Telephone: (H) ___________(Cell)_____________
Last First MI
Address: ____
Street/Apt.# City State Zip

Employee #:__________________________ DOB:___________ Sex:____ Marital Status:_____________

PERSON(S) NOTIFY IN CASE OF EMERGENCY

1. Name:____________________________________ Telephone: (H) ___________________(W) ____________
   Relationship:_______________________________ (Cell Phone/beeper) ______________________________
2. Name:____________________________________ Telephone: (H) ___________________(W) ____________
   Relationship:_______________________________ (Cell Phone/beeper) ______________________________

FAMILY PHYSICIAN

____ Telephone: ____________________

____
Address City State Zip

HOSPITAL PREFERENCE

❑ Peninsula Regional Medical Center ❑ Atlantic General Hospital ❑ Other: ____________________

REGULAR MEDICATIONS: I take the medications listed below on a regular basis:

Medication	Dosage	Medication	Dosage
____________	_______	_____________	_______
____________	_______	_____________	_______

EMERGENCY MEDICAL INFORMATION: I have or am subject to (check and give details):

____ Allergy to a medicine, food, plant, animal, or insect toxin (explain below)

____ Any condition that may require special care, medication, or diet (explain below)

_____ Asthma _____ Bleeding disorders _____ Contact lenses _____ Convulsions
_____ Dentures _____ Diabetes _____ Fainting spells _____ Heart trouble
_____ Other (explain)

Explanation: ____
____
____

To the best of my knowledge, the information above is accurate and complete. I give my permission in the event of illness or accident to institute medical treatment per the judgment of emergency personnel. Further, I understand all information is confidential and will be shared on a need-to-know basis only.

Signature: ____ Date: ___________