EMPLOYEE MEDICAL EMERGENCY RECORD

Date of Birth:_____

Name:_____

Address:_____

Phone:_____

EMERGENCY CONTACTS:

Name:_____**Relationship:**_____**Phone:**_____

Name:_____**Relationship:**_____**Phone:**_____

Name:_____**Relationship:**_____**Phone:**_____

DOCTOR:_____

MEDICAL CONDITION(S) THAT YOU WOULD LIKE YOUR EMPLOYER TO KNOW ABOUT IN CASE OF AN EMERGENCY:

_____

_____

CURRENT MEDICATION(S):

_____

_____

MEDICATION ALLERGIES:

_____

_____

I AUTHORIZE THE USE OR DISCLOSURE OF THE ABOVE INFORMATION TO EMERGENCY PERSONNEL IN THE EVENT OF AN EMERGENCY:

PRINTED NAME:_____

SIGNATURE:_____

DATE:_____

CONFIDENTIALITY STATEMENT: Medical-related information shall be kept confidential and maintained separate from other personnel records.