

EMPLOYEE EMERGENCY INFORMATION

NAME: _____

LAST

FIRST

HOME PHONE: _____ CELL: _____

ADDRESS: _____

I wish to voluntarily disclose to RFE and ASD that I suffer from the following medical conditions/allergies. I am sharing this information so that in the case of a medical emergency this information can be shared with RFE/ASD First Responders and/or Emergency Medical Personnel. This information will be stored in Human Resources and will not be shared except on a need to know basis.

MEDICAL CONDITION/ALLERGY

1. _____
2. _____
3. _____

I AM ALLERGIC TO THE FOLLOWING MEDICATIONS

1. _____
2. _____
3. _____

I AM CURRENTLY TAKING THE FOLLOWING MEDICATIONS

1. _____
2. _____
3. _____

_____ I **decline** to share my medical conditions/allergies.

Initials

PLEASE CONTACT IN CASE OF EMERGENCY

NAME: _____ RELATIONSHIP: _____

PHONE NUMBER: _____ ALT. PHONE: _____

ALTERNATE CONTACT: _____

PHONE NUMBER: _____ ALT. PHONE: _____

EMPLOYEE SIGNATURE: _____

DATE: _____ WITNESS: _____