Parkview School District
Employee Emergency Information

Employee Name _____

Date of Birth ____/____/____ **Home Telephone** _____

Cell Phone (if applicable) _____

Home Address _____

_____

Health Care Provider _____

Physician Name & Telephone # _____

Hospital of Choice _____

Facts concerning your medical history, including allergies, medications being taken and any physical impairments to which your co-workers and physicians should be alerted are as follows:

_____

_____

_____

Name of Spouse/Significant other _____

Employer _____ **Daytime Phone #** _____

Alternate Contact Person _____

Employer _____ **Daytime Phone #** _____

Optional Emergency Treatment:
I, the undersigned, do hereby authorize officials of the Parkview School District to contact directly the persons deemed necessary in an emergency, for the sake of my health. In the event physicians or others named on this card cannot be contacted, school officials are hereby authorized to take whatever action is deemed necessary in their judgment, for my health. I will not hold the school district financially responsible for my emergency care and/or transportations.

I agree/disagree to give permission for my emergency treatment.

_____ _____

Employee Signature **Date**