



Emergency Information Card

Are you allergic to any medication? ___Yes ___No

If yes, what? _____

List any medical precautions, daily medications, etc.

Date _____

Employee Name _____ Male ___ Female ___

Home Address _____ Phone () _____
Street City State Zip

Department _____ Hours at Office _____

Person to notify in case of emergency _____ Phone () _____

Address _____
Street City State Zip

1. Alternate Emergency Person _____ Phone () _____

Address _____
Street City State Zip

2. Out of Town Contact Person _____ Phone () _____

Address _____
Street City State Zip