SHERIDAN ALLPREP ACEDEMY – EMPLOYEE EMERGENCY CARD

Name ____ Birth Date _________________ Sex ____
E-Mail:____________________________ Phone ________________ Cell Phone ____________________
Address____
Spouse, Relative or Friend to be notified in case of illness or injury: (list two)
Name/Relationship____
Home Phone __________________________________ Work Phone ______________________________
Name/Relationship____
Home Phone __________________________________ Work Phone ______________________________
Physician/Medical Group _____________________________________ ID# ________________________
Address ____Phone ______________________
Dentist ______________________ Address _________________________ Phone __________________
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A. Please check the following items if they pertain to you:

- € Wear Contact Lenses
- € Wear Hearing Aid
- € Wear dental appliance

Other (specify):
____

B. Subject to any conditions which may result in an emergency, such as: (Please indicate special instructions, if any)
a. Seizure Disorder: ____
b. Respiratory Disorder: ____
c. Diabetes: ____
d. Cardiovascular or Bleeding Disorder: ____
e. Known Allergies: (food, drugs, insects, etc.) ____
C. Other known problems or medic alert information: ____
D. Do you take routine medication? Yes No If yes, name the medication and dosage
____
Anticipated reaction, if any ____
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In an emergency, I authorize a representative of the school to make such arrangements as he/she considers necessary for me to receive medical/dental or hospital care, including necessary transportation. If said physician is not available at the time, I authorize such care and treatment to be performed by any licensed physician/dentist. I hereby agree to bear all costs incurred as a result of the foregoing.

Signature: ____ Date: ____________________________

OR

If you **DO NOT** choose to sign the above statement, please state action desired in the event of an accident or emergency:
____
____
____

Signature: ____ Date: ____________________________

Reviewed:
Date ______ Initials ___ Date ______ Initials ___ Date ______ Initials ___ Date ______ Initials ___