EMPLOYEE HEALTH FORM

8-2016

This form is optional, voluntary and for use in case of emergency.
(i.e. ambulance or physician)

Employee Name:_____

Mailing Address_____Apt.(etc.)_____

City, State_____Zip_____

Home#(_____)_____Cell#(_____)_____

Work Email:_____ @ccschools.k12tn.net

SPOUSE:

_____
Last First

_____
Spouse Workplace

Cell #_(_____)_____

Work#_(_____)_____

EMERGENCY CONTACT :

_____
Last First

Relationship:_____

Home#(_____)_____

Cell#(_____)_____

Work#(_____)_____

ALLERGIES (optional):_____

MEDICATIONS (REGULAR, OTC, PRESCRIPTION) *OPTIONAL:

_____
_____
_____
_____

LOCAL PHYSICIAN:_____PHONE(_____)_____

LOCAL PHYSICIAN:_____PHONE(_____)_____

COMMENTS:_____
_____

Signature indicates permission to release information to appropriate emergency personnel.

Signature_____Date:_____