



EAST MISSOURI ACTION AGENCY, Inc.

Head Start

“An Equal Opportunity/Affirmative Action Employer”

EMERGENCY MEDICAL FORM FOR HEAD START STAFF OR VOLUNTEERS

Name: _____

Address: _____

Home Phone: _____ Cell Phone: _____

Emergency Contacts:

Contact #1: _____ Phone: _____

Contact #2: _____ Phone: _____

Contact #3: _____ Phone: _____

Doctor: _____ Phone: _____

Dentist: _____ Phone: _____

Hospital: _____

Phone: _____

Illness: _____

Medications: _____

Allergies: _____

I, _____, authorize EMAA Head Start Staff to take me for emergency medical and dental treatment if necessary.

Date: _____

***On the job injuries will be handled according to EMAA Policy for Handling Work Injuries.