



“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.