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: _____

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.