Date: ____________________

CCCC – Employee Emergency Consent/Contact

Employee's Name: ______________________________ Birthdate: ______________

Address: ____

Home Phone#: ________________ Cell Phone#: ____________________

Spouse's Name: ______________________ Cell Ph#: ________________

Employer: __________________ Work Hours: _______ to _______ Work Ph# ______________

Additional Emergency Contacts:

Name: ____________________________ Relationship: __________________

Home Phone#: ________________ Cell Phone#: ____________________

Employer: __________________ Work Hours: _______ to _______ Work Ph# ______________

Name: ____________________________ Relationship: __________________

Home Phone#: ________________ Cell Phone#: ____________________

Employer: __________________ Work Hours: _______ to _______ Work Ph# ______________

Emergency Information:

Name of Physician/Medical Care Provider: ______________________________________

Address: ______________________________________ Ph#: ______________

Daily Medication (if any): ____

Allergies (including medication reaction): ______________________________________

Medical or Dietary Information which may be necessary in an emergency situation: ______________

____

Special Disabilities/Conditions: ____

SIGNATURE IS REQUIRED FOR EACH ITEM BELOW TO INDICATE CONSENT:

__________________________ Obtaining Emergency Medical Care

__________________________ Administration of minor first-aid procedures

Notes: *Transportation by ambulance to Lehigh Valley Hospital. *Employee Emergency Consent forms are kept in the Center Director's ERP binder.

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YEARLY REVIEW

Do not complete below until one year has passed!

Review and Sign below if all information above is current and correct:

__________________________ Signature

______________ Date
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