

## Emergency Contact Information

Emergency information needs to be available in case of a medical emergency please complete the bottom portion of this form.

Employee Name: \_\_\_\_\_

Name of Person to Contact in Case of an Emergency: \_\_\_\_\_  
(Note: Make sure the contact you list would know medications that you are taking)

Relationship to Employee: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

List any allergies: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

List any medical information that emergency services would need to know about in case of unconsciousness. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you keep a medication list on your person?  Yes  No If yes where is it located?

\_\_\_\_\_

By signing this form I am authorizing the Elizabeth Richardson Center to provide the above information to emergency personnel in cases of unconsciousness, injury or life threatening illness.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date