

RICHMOND HEIGHTS LOCAL SCHOOLS

EMERGENCY MEDICAL INFORMATION

Last Name First Name

Address City Zip Cell Phone

Personal Email Address (not work email) Home Phone

IN CASE OF EMERGENCY CALL:

Name & Relationship City Phone

Name & Relationship City Phone

Any Special Medical Conditions:

Allergies Required Medications

Family Physician Preferred Hospital

Phone # Phone #

Birthdate **Model of Car(s) and License #**

Spouse's Name

Spouse's Place of Employment

Address

Phone Number

Children(s) Names

In case of emergency, I give my permission to call a local doctor and/or take me to a hospital. This in no way makes the Richmond Heights Board of Education or its designated agent(s) liable for action or debts incurred.

Employee Signature **Date**

Cc: Building Principal/Supervisor
Personnel File