Gary's Emergency Contact Form

Date:_____

Name: (First, Middle, Last)_____

Address:_____ City _____ State____ Zip _____

Your Primary Cell Phone Number:_____

Secondary (house or family) Number:_____ Is this a cell #?___

Birth Date:_____ Age as of today's date?_____

Emergency Information

Primary Contact:_____ Relationship:_____

Their Primary Cell Phone Number:_____

Their Secondary (house or family) Number:_____ Is this a cell #?___

Address:_____ City _____ State____ Zip _____

Secondary Contact:_____ Relationship:_____

Their Primary Cell Phone Number:_____

Their Secondary (house or family) Number:_____ Is this a cell #?___

Address:_____ City _____ State____ Zip _____

Medical Information (optional)

Primary Care Physician:_____ Phone:_____

Preferred Hospital:_____

Information that may be helpful in the event of an emergency (i.e. allergies, known medical conditions, treatment needed –epi pen, medication, etc,)

_____

_____

_____

Employee Signature:_____

Print Parent/Guardian Name:_____

Parent/Guardian Signature if under age 18:_____