WESTPORT COMMUNITY SCHOOLS

VOLUNTEER EMERGENCY FORM

Please note: The following information is optional and will be held in strict confidence in the Nurse's office. This information will be used only in an emergency situation.

Name: _____

Today's Date: _____ Date of Birth: _____

Cell Phone: _____ Home Phone: _____

Address: _____

Family Physician: _____ Telephone:_____

Preferred Hospital/Clinic for Emergency Care:_____

Do you presently take medication: ○ Yes ○No

If so, please list name/dosage/times of all medication(s):_____

_____

Do you have any medical problems or allergies? _____

_____

PERSON TO NOTIFY IN AN EMERGENCY:

Name: _____ Relationship:_____

Home Phone: _____ Cell/Work Phone:_____

Name: _____ Relationship:_____

Home Phone: _____ Cell/Work Phone:_____

Any other information you feel emergency personnel should be made aware of: _____

_____

_____

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