

School Year
2013-2014

Tiffin City Schools
Staff Emergency Medical Form

Building: _____

Name _____ Phone number _____

Address _____ City, State, Zip _____

Title _____ Date of Birth _____

Allergies _____

Medications _____

IN CASE OF MEDICAL EMERGENCY, SCHOOL OFFICIALS SHOULD CONTACT:

Primary Contact

Secondary Contact

Name _____

Relationship _____

Employer _____

City _____

Daytime
Phone Number _____

Daytime Cell
Phone Number _____

Physician _____

Physician Phone _____

Dentist _____

Dentist Phone _____

Hospital _____

Hospital Phone _____

I give my consent that in the event that my doctor and/or dentist is not available, another licensed medical professional in the field may administer treatment deemed necessary. If my preferred hospital is too far away, I give permission to be transported to any hospital reasonably accessible. (MUST check one) ___ Yes ___ No

Signature _____

Date _____

I do **NOT** give my consent for emergency medical treatment. In the event of illness or injury requiring emergency treatment, I wish authorities to take the following action: _____

Signature _____

Date _____