# Upper Bucks County Technical School

## Nurse's Office

## TO ALL EMPLOYEES OF UPPER BUCKS COUNTY TECHNICAL SCHOOL

Attached please find an Employee **Emergency Health Information Form.** The information on this form is **strictly confidential.**

**Return to me ASAP**

It is very important that, in case of an emergency, I have basic medical history, some background information and emergency contacts on file for all employees.

Please take a moment to complete this form and remember to keep your emergency medical information current throughout the year.

*****IF you begin a new medication or are newly diagnosed during this school year, please submit the updated information promptly, so our records are accurate at all times, and you can receive appropriate medical treatment.

Feel free to contact me with regard to any concerns you may have. I look forward to a safe and healthy year for everyone at UBCTS. Thank you for your cooperation.

# UPPER BUCKS COUNTY TECHNICAL SCHOOL EMERGENCY INFORMATION

*Complete Both Pages and Sign Page 2*

Name: ___________________________________________ Birthdate: _____________________

Where do you work in the school? _________________________________________________

Position____________________________________________________________________________

Home Address: ________________________________________________________________________

Phone Number: (H)___________________________ (C)_________________________________

Emergency Contacts:

1. Person's Name: ______________________________________________

   Relationship to You: __________________________________________

   Person's Phone Number: ______________________________________

2. Person's Name: ______________________________________________

   Relationship to You: __________________________________________

   Person's Phone Number: ______________________________________

Existing Medical Conditions: ______________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

**Allergies** (any/all) and Reactions:

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

**Current Medications** (name, dosage and frequency):_________________________________

___________________________________________________________________________________

___________________________________________________________________________________

History (Any pertinent medical information that should be known in case of an emergency)

___________________________________________________________________________________

___________________________________________________________________________________

___________________________________________________________________________________

Do you have a pacemaker or any other implanted medical device? _________________

Doctor's Name: ______________________________ Phone #___________________________

Hospital Affiliated with: _______________________ Phone # _________________________

Special Instructions in Case of Emergency:

_________________________________________________________________________________

_________________________________________________________________________________

Permission for Hospital/Emergency Treatment: YES NO (Circle one)

***Print Name:*** _______________________________________

***Signature:*** ________________________________________ ***Date:***_____________________