

AURORA CITY SCHOOLS STAFF EMERGENCY FORM

DATE SUBMITTED: _____

Completion of all or part of this form is optional. Submission of the completed form allows the office to have it on file should an emergency arise involving you.

NAME _____ BIRTH DATE _____

ADDRESS _____

HOME PHONE w/ Area Code _____ CELL PHONE w/ Area Code _____

ALLERGIES, PHYSICAL NEEDS, OR HEALTH CONDITIONS _____

MEDICATION TAKING _____

PHYSICIAN: NAME _____

ADDRESS _____

CITY _____

PHYSICIAN PHONE w/ Area Code _____

PREFERRED HOSPITAL _____

HOSPITAL PHONE w/ Area Code _____

IN CASE OF EMERGENCY, PLEASE CALL:

HOME

WORK

NAME _____

COMPANY _____

ADDRESS _____

ADDRESS _____

PHONE w/ Area Code _____

PHONE w/ Area Code _____

CELL w/ Area Code _____

ALTERNATE PERSON:

HOME

WORK

NAME _____

COMPANY _____

ADDRESS _____

ADDRESS _____

PHONE w/ Area Code _____

PHONE w/ Area Code _____

CELL w/ Area Code _____

Please complete and return this form to your building office.