EMPLOYEE EMERGENCY CONTACT FORM

Name: _____

Position: _____

D.O.B._____ Social Security No.: _____

Address: _____ City: _____

Zip: _____

Home Phone: _____ Cell Phone:_____

Allergies _____

Medication Currently Being Taken _____

Special Medical Considerations _____

_____

In case of emergency, please notify:

Name _____ Relationship _____

Phone(s) _____

Name _____ Relationship _____

Phone(s) _____

In case of serious illness or injury, I authorize the Ionia County Intermediate School District to secure necessary medical treatment for me. Special requests, if any are: _____

_____

_____

☐ **By checking this box, I do not want ISD personnel to release my home address to other ISD employees.**

☐ **By checking this box, I give permission to the ICISD to discuss financial and medical situations with the named above or listed here:** _____

Signature _____ Date _____

(rev. 12/2023)