



EMPLOYEE EMERGENCY CONTACT FORM

Name: _____

Position: _____

Personal Information:

Home Address: _____

Home Phone: _____ Cell Phone: _____

Primary Emergency Contact:

Name _____ Relationship _____

Phone(s) _____

Secondary Emergency Contact:

Name _____ Relationship _____

Phone(s) _____

Medical Information:

Allergies _____

Medication Currently Being Taken _____

Special Medical Considerations _____

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 _____