



Teacher Emergency Form

YEAR _____

Name: _____

Date of birth: ____ / ____ / ____

In an emergency, please contact:

_____ Relationship to you: _____

Ph: _____ home _____

Ph: () _____ cell

Ph: () _____ work

In case of area disaster, contact (living outside the Bay Area):

_____ Ph: () _____

Your home address

_____ Home ph. #:() _____

_____ Cell ph. #: () _____

Physician: _____ **Phone #:** () _____

Health insurance company: _____

Policy #: _____ Group #: _____

Allergies (food and medication): _____

Other Medical Conditions: _____

Last tetanus vaccination: ____ / ____ / ____

Waiver for emergency medical treatment:

If I need medical treatment either on campus or off campus during school hours and am incapable of giving consent (i.e. unconscious), I understand that all efforts will be made to reach my emergency contacts before I receive treatment. However, I give my consent for any emergency medical treatment needed and I understand that I am responsible for all costs incurred.

Signature: _____ Date: _____