

**Elko County School District
Emergency/Medical Information**

**CONFIDENTIAL HEALTH INFORMATION
SPRING CREEK ELEMENTARY**

EMPLOYEE

Name: _____ **Date of Birth:** _____

Home Address: _____

Home Phone: _____

Medication Allergies: _____

Pertinent Medical History/ Conditions: _____

Previous Surgeries: _____

Current Medications: _____

PRIMARY PHYSICIAN

Name: _____

Office Name: _____

Office Phone: _____

EMPLOYEE'S SIGNIFICANT OTHER/SPOUSE

Name: _____

Employment: _____

Employment Phone: _____

Cell Phone: _____

ADDITIONAL EMERGENCY CONTACTS

Name: _____

Relation: _____

Phone: _____

Name: _____

Relation: _____

Phone: _____

This information is kept confidential and is strictly volunteered. This information would only be used in the event of an emergency and used only to provide prompt medical attention and/or information to the medical personnel, hospital, or ambulance. I authorize officials of the Elko County School District or my emergency contact person to contact my Doctor: _____ or the Emergency Room Physician. I give permission to carry out necessary procedures to treat the medical emergency.

Signature: _____ **Date:** _____