Zebra Crossings Staff Emergency Form

Name ____ Date ____/____/____
Last   First   Middle

Primary Emergency Contact:

Name ____ Relationship _____________

Address ____

City ____________________________________ State _______ Zip _____________

Phone ______________________   Phone (*Alt*) _______________________

Alternate Emergency contact:

Name ____ Relationship _____________

Phone ______________________   Phone (*Alt*) _______________________

Basic Health Information:

Current Medications ____

____

Allergies ____

____

Dietary Needs ____

Other Conditions/Limitations we should be aware of ___________________________

____

Health Care Provider and Insurance Information:

Health Care Provider____

Clinic Name ____

Address_________________________________Phone ________________________

City _________________________________ State ____________ Zip ___________

Insurance Company ___________________________ Member/Policy Number _______________

PERMISSION TO TREAT:

I give permission to Zebra Crossings and their staff or designated personnel to seek emergency treatment for the me in the case of emergency including surgical procedures. I have completely answered all of the questions on this form and have provided complete medical information relevant to the proper care and treatment. I understand the omission of information may jeopardize my health. I give to share the minimum necessary information related to the physical and mental health with medical providers and/or emergency personnel, as she/he determines is necessary for my health and safety. I expect that information shared will be respected as confidential by Zebra Crossings personnel.

_____________________________   _____________________________

Signature of Staff/Volunteer   **Date**