D'Youville COLLEGE

DATE: _____

EMPLOYEE EMERGENCY INFORMATION

The following employee information will be kept confidentially in the Health Center and HR and utilized only in the event of a medical emergency

Please notify the Health Center to update information as changes occur.

NAME: _____

DEPARTMENT: _____

HOME ADDRESS: _____

CELL PHONE #:_____ DOB: _____

IN CASE OF AN EMERGENCY:

PLEASE NOTIFY: _____

PHONE NUMBER: _____ RELATIONSHIP: _____

PHYSICIAN's NAME: _____

ADDRESS: _____

PHONE NUMBER: _____

HOSPITAL OF CHOICE: _____

I have the following allergies or drug reactions (Print "NONE" if none exist)

_____
_____
_____

I have a pre – existing condition (please explain)

_____
_____
_____

INSURANCE CARRIER: _____

GROUP NUMBER: _____ PLAN NUMBER: _____

IDENTIFICATION NUMBER: _____