

**Shawnee State University  
Children's Learning Center**

**Employee Emergency Procedure Form**

Employee's Name _____	Birth Date _____
Home Address _____	Home Phone _____
Campus Address _____	Campus Phone _____
E-mail address _____	Cell Phone _____
Spouse's Name _____	Cell Phone _____
Spouse's Business Address _____	Phone _____
Name of Close Relative _____	Phone _____
Name of Neighbor _____	Phone _____

In the event that the above cannot be contacted, it may be necessary to call an ambulance to take you to the hospital.

Preferred Hospital _____	Phone _____
Family Doctor _____	Phone _____
Family Dentist _____	Phone _____
Family Eye Doctor _____	Phone _____

In the event that your doctor cannot be contacted, another doctor on the hospital staff will be called.

Your signature below will authorize permission to the hospital or physician to administer medical aid which may be necessary at the time for your safety and well being.

Name of hospitalization plan \_\_\_\_\_

Name of Insured \_\_\_\_\_ Plan/Group No. \_\_\_\_\_

Please list below other medical or physical conditions related to your health you would like to call to our attention such as:

Allergy to medication	_____
Medications taken	_____
Heart condition	_____
Epilepsy	_____
Diabetes	_____
Hemophilia	_____
Contact lenses	_____
Other	_____

Employee's Signature \_\_\_\_\_ Date \_\_\_\_\_