CCM HEALTH SERVICES
MEDICAL EMERGENCY INFORMATION

Name: _____

Address: _____

_____

Home Phone: _____ Cell Phone: _____

Date of Birth: _____ Hire Date: _____

CAMPUS INFORMATION: (please check)

_____ Faculty _____Staff _____ Adjunct Faculty _____ Temporary

Department: _____ Extension: _____

Position: _____

EMERGENCY INFORMATION:

In case of a medical emergency, please notify:

Name: _____

Work/Home Phone: _____ Cell Phone: _____

Relationship: _____

MEDICAL INFORMATION:

Allergies: (Please circle) YES NO

If yes, please list _____

Physician's Name: _____

City/State: _____ Phone: _____

Are you presently under medical care?: YES NO

If yes, please specify: _____

Please specify any regular medications taken: _____

_____

Please write any additional information and/or instructions you feel would be of assistance to the nurse in an emergency situation on the back of this form. Thank you.

DD 10/11