



STUDENT EMERGENCY CONTACT INFORMATION

Employee Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone Number: _____ Cell Phone Number: _____

Date of Birth: _____ Base county: _____

IN CASE OF EMERGENCY NOTIFY:

Name: _____ Relationship: _____

Home Phone Number: _____ Cell Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

IF UNABLE TO REACH ABOVE NOTIFY:

Name: _____ Relationship: _____

Home Phone Number: _____ Cell Phone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Please list any conditions or medications that you would like for Lincoln Trail District Health Department to notify Emergency Medical Services of if the need arises:

(Optional)

Student Signature _____ Date: _____