



**City of Middletown Part-Time
EMPLOYEE EMERGENCY INFORMATION**

Name: _____ Date of Birth: ____/____/____

Address: _____

Home Phone: (____)-_____ Emergency Daytime Phone (____)-_____

List any health concerns (allergies, bee stings, food allergies, physical limitations, etc.): _____

Do you take medication? _____ If yes, please list: _____

Are there any side effects? _____

(Any time an employee is on a medication, it is his/her responsibility to notify their immediate supervisor)

Do you wear braces? _____

Physician's Name: _____ Phone (____)-_____

Parent/Guardian/Spouse Name:

Address: _____
Street City Zip

Home Phone: (____)-_____ Work Phone: (____)-_____

If parent/guardian/spouse cannot be reached, list two people that can be called in an emergency:

Name: _____ Relationship: _____ Daytime Phone: _____

Name: _____ Relationship: _____ Daytime Phone: _____

Any other information you feel we should know: _____

Signature _____ Date ____/____/____
