FREMONT CITY SCHOOLS
500 W. State Street, Suite A, Fremont, Ohio
419-332-6454

EMPLOYEE EMERGENCY MEDICAL AUTHORIZATION

Date_____ **Location/Building** Substitute

Staff Member's Name_____ _____
(Last) (First) (MI)

Address_____ _____ _____
(City/State (Zip)

Phone: _____ **Birthday**_____ (optional) **Anniversary**_____ (optional)

Spouse_____ _____
(Last) (First)

Home Phone_____ **Work Phone**_____ **Cell Phone**_____

Spouse Employer_____ _____
(Address)

Employer Phone_____

If unable to reach the above listed spouse, please make an effort to contact one of the persons listed below in case of an emergency:

_____ _____ _____
(Name) (Relationship) (Address)

_____ _____ _____ _____
(Home Phone) (Cell Phone) (Employer) (Phone)

_____ _____ _____
(Name) (Relationship) (Address)

_____ _____ _____ _____
(Home Phone) (Cell Phone) (Employer) (Phone)

In the event of illness or injury requiring emergency treatment, a designated school official and/or school employee shall immediately make every reasonable effort to contact a public or private rescue agency at my expense.

It is understood that nothing in this form shall be construed to impose liability in civil damages on the board of education, school administration, and/or school employee unless gross negligence or wanton or reckless misconduct can be substantiated. It is further understood that information on this form cannot be construed as a condition for employment.

_____ _____ _____
Preferred Medical Physician Address Phone

_____ _____ _____
Preferred Specialist Address Phone

_____
Preferred Hospital (Unless there is a need for the nearest facility)

Signature of Employee:_____

cao021012
Staff