URBAN TRIAGE

RETURNING TO OUR PAST TO HEAL FOR OUR FUTURE

EMERGENCY CONTACT INFORMATION

Name: _____ Circle One: Employee | Volunteer

Emergency Contacts

First Contact: _____

Address: _____

Relationship: _____ Phone #: _____

Second Contact: _____

Address: _____

Relationship _____ Phone #: _____

Preferred Medical Contact

Physician Name: _____

Primary Clinic Name: _____

Clinic Address: _____

Clinic Phone #: _____

Hospital Preference: _____

Special Emergency Medical Information: Please describe any special circumstances or medical information which may affect treatment or which presents special health risks in the event of an emergency. This information may include a heart condition, allergies to medication, prescription and non-prescription medicines you are taking, etc.

_____

_____

_____

_____

I certify that all information on this form is accurate and provided voluntarily.

_____ _____

Signature Date