California Association for Bilingual Education

Staff Emergency Information

Instructions: Please print clearly. Please notify H.R. personnel of any changes/revisions of this information.

FIRST NAME	LAST NAME	DATE OF BIRTH

HOME PHONE NO. (IF APPLICABLE)	CELL PHONE NO.	SOCIAL SECURITY NO.

STREET ADDRESS (CITY, STATE, ZIP)	EMAIL ADDRESS

*PERSON TO CONTACT IN CASE OF AN EMERGENCY	RELATIONSHIP

STREET ADDRESS (CITY, STATE, ZIP)	CELL PHONE NO.	WORK PHONE NO.

*ALTERNATE CONTACT IN CASE OF AN EMERGENCY	RELATIONSHIP

STREET ADDRESS (CITY, STATE, ZIP)	CELL PHONE NO.	WORK PHONE NO.

*PHYSICIAN'S NAME AND ADDRESS (CITY, STATE, ZIP)	PHYSICIAN'S PHONE NO.	HOSPITAL PREFERENCE

CURRENT HEALTH CONDITIONS - ☐ASTHMA ☐ DIABETES ☐ALLERGIES ☐SEIZURES ☐HEART CONDITION ☐ OTHER	EXPLANATION OF HEALTH CONDITIONS

MEDICATIONS: ARE YOU TAKING REGULAR MEDICATION? ☐YES ☐ NO	LIST THE NAME(S) OF ALL REGULAR MEDICATIONS

ADDITIONAL INFO. TO ASSIST IN CASE OF EMERGENCY: CALIFORNIA DRIVER'S LICENSE NO. _____

CAR MAKE _____ CAR MODEL _____ LICENSE PLATE NO. _____

*In case of accident or serious illness, CABE will contact the person(s) listed. If CABE is unable to contact either person designated above, CABE will contact the physician or will make the necessary arrangement for immediate transportation and treatment. Payment of fees will be assumed by staff member. I permit this information to be shared with emergency medical professionals in the case of a medical emergency.

I have reviewed and understand the conditions of this document and I understand that if I desire any alternate emergency procedures than those listed above, I must provide a list of my preferences in writing, with all applicable addresses or phone numbers, to the proper CABE personnel.

X

Signature Date