

**WASHINGTON UNIFIED SCHOOL DISTRICT – EMPLOYEE EMERGENCY CARD**

Assignment Site \_\_\_\_\_ Birth Date \_\_\_\_\_ Sex \_\_\_\_ E-Mail: \_\_\_\_\_  
Name \_\_\_\_\_ Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Address \_\_\_\_\_  
Spouse, Relative or Friend to be notified in case of illness or injury: (list two)  
Name/Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Name/Relationship \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Physician/Medical Group \_\_\_\_\_ ID# \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Dentist \_\_\_\_\_ Address \_\_\_\_\_ Phone \_\_\_\_\_

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***For work related injuries, the District has a designated facility for treatment. If you prefer to be treated by your personal physician for work related injuries, you must complete a pre-designated form prior to the injury. Pre-designation forms can be obtained from the Human Resources Department or Risk/Benefits Manager.***

4112-6-PER/4212-7-PER (Revised 10/2008)

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4112-6-PER/4212-7-PER (Revised 10/2008)

- A. Please check the following items if they pertain to you:  
 Wear Contact Lenses       Wear Hearing Aid       Wear dental appliance  
 Other (specify): \_\_\_\_\_
- B. Subject to any conditions which may result in an emergency, such as: (Please indicate special instructions, if any)  
 a. Seizure Disorder: \_\_\_\_\_  
 b. Respiratory Disorder: \_\_\_\_\_  
 c. Diabetes: \_\_\_\_\_  
 d. Cardiovascular or Bleeding Disorder: \_\_\_\_\_  
 e. Known Allergies: (food, drugs, insects, etc.) \_\_\_\_\_
- C. Other known problems or medic alert information: \_\_\_\_\_
- D. Do you take routine medication? Yes  No  If yes, name the medication and dosage \_\_\_\_\_  
 Anticipated reaction, if any \_\_\_\_\_
- E. Registered person living in immediate household of unit member (In accordance with WTA and CSEA agreements, effective 1/2/90) \_\_\_\_\_

In an emergency, I authorize a representative of the school district to make such arrangements as he/she considers necessary for me to receive medical/dental or hospital care, including necessary transportation. If said physician is not available at the time, I authorize such care and treatment to be performed by any licensed physician/dentist. I hereby agree to bear all costs incurred as a result of the foregoing.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If you **DO NOT** choose to sign the above statement, please state action desired in the event of an accident or emergency: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed: Date \_\_\_ Initials \_\_\_ Date \_\_\_ Initials \_\_\_ Date \_\_\_ Initials \_\_\_ Date \_\_\_ Initials \_\_\_

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