reach DANE

White – Classroom/Site
Pink – HR File
Yellow –Licensing File

Volunteer EMERGENCY

Location/Program: _____ Check appropriate box: ☐ M ☐ F

Name (Last, First) Date of Birth

Address Apt. City/Town Zip Telephone Number

Name of Emergency Contact Person (Last, First) Relationship Telephone Number During Volunteer's Work Hours

MEDICAL INFORMATION

Physician Name

Address

City/Town Zip Telephone Number

Dentist Name

Address

City/Town Zip Telephone Number

Hospital Preference Address City/Town Zip Telephone Number

Do You Have: ☐ Severe Allergies ☐ Diabetes ☐ Asthma ☐ Seizure Disorder

☐ Other Significant Health Problems? **(Please Explain)** _____

Medication Allergies (Please List) _____

SIGNATURE_____ **Date**_____

Email Address_____