STAFF/VOLUNTEER
EMERGENCY MEDICAL/DENTAL FORM

Attention Medical Personnel: This is to authorize Douglass Community Services staff to seek medical/dental help for me during attendance and/or working/volunteering hours. I hereby authorize medical personnel to administer medical/dental care to me, if I am incapacitated.

Name:_____ Work/Volunteer Site:_____

Address: _____ Phone#:_____

Physician Contact Info (optional):
_____
_____
_____
PH#:_____

Known drug allergies:_____

Other Allergies:_____

Do you have a disability that may affect your ability to perform the essential functions of your position with or without a reasonable accommodation? __ No __ Yes
Explain: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Employee/Volunteer Signature: _____

Today's Date: _____

EMERGENCY CONTACT:

(1) Name and Address
_____
_____
_____

Home/Cell phone: _____ Work phone: _____

VOLUNTEERS ONLY*

Please provide Probation/Parole Officer contact information if being ordered to perform community service hours:

(2) Name and Address
_____
_____
_____

Work phone: _____

Employee/Volunteer Signature: _____ Date:_____