



WESTPORT COMMUNITY SCHOOLS

VOLUNTEER EMERGENCY FORM

Please note: The following information is optional and will be held in strict confidence in the Nurse's office.
This information will be used only in an emergency situation.

Name: _____

Today's Date: _____ Date of Birth: _____

Cell Phone: _____ Home Phone: _____

Address: _____

Family Physician: _____ Telephone: _____

Preferred Hospital/Clinic for Emergency Care: _____

Do you presently take medication: ☐ Yes ☐ No

If so, please list name/dosage/times of all medication(s): _____

Do you have any medical problems or allergies? _____

Car Make: _____

Car Model: _____

Car Color: _____

License Plate: _____

PERSON TO NOTIFY IN AN EMERGENCY:

Name: _____ Relationship: _____

Home Phone: _____ Cell/Work Phone: _____

Name: _____ Relationship: _____

Home Phone: _____ Cell/Work Phone: _____

Any other information you feel emergency personnel should be made aware of: _____
