

## BMS Staff Emergency Information

Name:			
Address:			
Contact persons in case of emergency:			
Name:	Relation:	Home:	
Address:		Work:	
Email:		Cell:	
Name:	Relation:	Home:	
Address:		Work:	
Email:		Cell:	
Physician:		Phone:	
Health Insurer:		Policy No.:	
Known Allergies:			
Medications Currently Taking:			
Hospital Preference:			
Special Health Conditions:			
Vehicle information: (Required for St. Ann Campus)			
Make:	Model:	Plate#:	Color:

In case of a medical emergency, I understand that I will be transported to an appropriate medical facility by the local emergency unit for treatment if the local emergency resource deems it necessary.

It is understood that in some medical situations, the local emergency resource will need to be contacted before contacting your physician and your specified contact person.

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

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