

Grayling High School Faculty Emergency Information

Name _____

Address _____ City _____ State _____ Zip _____

Mailing Address (if different) _____

Phone: _____

Occupation (teacher, custodian, etc.) _____

Health Insurance Information:

(Priority) _____

(SET SEG) _____

Insurance Company

Insurance Company

Enrollee Name

Enrollee Name

Contract #

Member ID#

Group #

Account #

Person to notify in case of emergency

1st choice: _____ Phone # _____

2nd choice: _____ Phone # _____

Family doctor: _____ Blood type (if known) _____

Allergies: _____

Special Instructions or Medical Conditions/Medications: _____

Instructions for Medical Treatment: _____

The Crawford AuSable School District has my permission to direct emergency treatment for myself, in the event I cannot act on my own behalf, which may include first aid, hospital, emergency room treatment, etc.

Signature: _____

Date: _____