JARRELL ISD
CHANGE OF EMERGENCY INFORMATION

Employee Name: ____

<u>EMERGENCY CONTACT INFORMATION</u> (Required)

Emergency Contact Name: ____

Relationship: __________________________ Phone Number:______________________________

<u>HEALTH INFORMATION</u> (Optional)

Do you have any serious allergies the district needs to be aware of? **YES** **NO**

If yes, please list: ____

Have you had any surgeries? **YES** **NO**

If yes, please list: ____

Do you have any specific medical problems or physical limitations the district should know about?
YES **NO**

If yes, please list: ____

Do you currently take any medications? **YES** **NO**

If yes, please list: ____

By submitting this form I authorize Jarrell ISD Human Resources department to update my emergency contact and health information.

I hereby authorize the physician, surgeon or dentist to administer any emergency treatment, procedure or medicine necessary and advisable. I authorize the use of an ambulance if necessary. I understand that my health information will only be released to a medical professional for emergency purposes only.

Employee Signature: ____ **Date:** ______________

Please return form to hr.dept@jarrellisd.org