

# Autistic Services, Inc.

## Employee Emergency Medical Information and Change of Address Form

Emergency for this purpose is defined as a potentially life threatening situation or a situation in which an employee is unable to make a clear medical decision for themselves. 911 will be contacted prior to listed emergency contacts when the following conditions present:

- Unconscious
- Life threatening conditions (i.e. hemorrhage, heart attack, respiratory distress, etc.)
- Altered mental status (i.e. incoherent, disoriented, etc.)

It is the employee's responsibility to promptly notify Human Resources of any change to the Emergency Medical Form.

Employee Name \_\_\_\_\_  
Address \_\_\_\_\_  
City/State/Zip \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell \_\_\_\_\_  
Date of Birth \_\_\_\_\_

**People to notify in case of emergency:**

(1) Name \_\_\_\_\_  
Address \_\_\_\_\_  
Phone \_\_\_\_\_ Cell \_\_\_\_\_

Health Insurance \_\_\_\_\_  
Group Number \_\_\_\_\_ ID # \_\_\_\_\_  
Physician's Name \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Hospital Preference \_\_\_\_\_

**(Please note: Preference will be considered if determined medically stable by EMS personnel).**

Allergies \_\_\_\_\_

The information included wherein will be kept confidential with limited access (i.e. M.D., R.N., Executive Director, Human Resources and Program Administration) and disclosed only as medically necessary (i.e. EMS personnel, emergency room personnel).

I authorize Autistic Services, Inc. to secure medical care or first aid for me as indicated above, and if I am unable to do so for myself, I release Autistic Services, Inc. from any liability for the care they secure for me in my best interest.

\_\_\_\_\_  
Employee Signature Date

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**FOR HUMAN RESOURCES USE ONLY**

\_\_\_\_ IHA \_\_\_\_\_ HRA \_\_\_\_\_ HRIS  
\_\_\_\_ Dental \_\_\_\_\_ Profit Sharing