CITY OF SAN BRUNO – EMERGENCY RESPONSE PLAN

RETURN COMPLETED FORM TO HUMAN RESOURCES DEPARTMENT

❶ EMPLOYEE

EMPLOYEE NAME (Last) (First) (Middle)		HOME PHONE #
POSITION	DEPT / DIVISION	CELLULAR #
HOME ADDRESS (Street) (City) (State) (ZIP)		OTHER #

❷ PRIMARY EMERGENCY CONTACT

NAME (Last) (First)	RELATIONSHIP	HOME PHONE #
HOME ADDRESS (Street) (City) (State) (ZIP)		CELLULAR #
PLACE OF WORK		WORK PHONE #
WORK ADDRESS (Street) (City) (State) (ZIP)		OTHER #

❸ SECONDARY EMERGENCY CONTACT

NAME (Last) (First)	RELATIONSHIP	HOME PHONE #
HOME ADDRESS (Street) (City) (State) (ZIP)		CELLULAR #
PLACE OF WORK		WORK PHONE #
WORK ADDRESS (Street) (City) (State) (ZIP)		OTHER #

❹ CHILD CARE PROVIDER (Optional)

NAME	PHONE #
ADDRESS (Street) (City) (State) (ZIP)	OTHER #
LIST NAME(S) / AGE(S) OF INDIVIDUAL(S) BEING CARED FOR BY THIS PROVIDER	

❺ ELDER CARE PROVIDER (Optional)

NAME	PHONE #
ADDRESS (Street) (City) (State) (ZIP)	OTHER #
LIST NAME(S) OF INDIVIDUAL(S) BEING CARED FOR BY THIS PROVIDER	

❻ FAMILY MEMBERS ATTENDING SCHOOL (Optional)

NAME (Last, First)	SCHOOL	STREET ADDRESS	CITY	SCHOOL PHONE #	GRADE
NAME (Last, First)	SCHOOL	STREET ADDRESS	CITY	SCHOOL PHONE #	GRADE
NAME (Last, First)	SCHOOL	STREET ADDRESS	CITY	SCHOOL PHONE #	GRADE

❼ PHYSICIAN

NAME (Last, First)	ADDRESS	CITY	ZIP	PHONE #

LIST NAME(S) AND ANY PHYSICAL PROBLEM, CONDITION OR ALLERGY OF ANY FAMILY MEMBER ON THE BACK OF THIS FORM.
ALSO NOTE ANY SPECIAL CONDITIONS (e.g. spouse/other speaks only Spanish)

❽ SIGNATURE

_____ EMPLOYEE SIGNATURE

_____ DATE

567 EL CAMINO REAL, SAN BRUNO, CA 94066

cc: Department