

CITY OF SAN BRUNO – EMERGENCY RESPONSE PLAN

RETURN COMPLETED FORM TO HUMAN RESOURCES DEPARTMENT

1 EMPLOYEE					
EMPLOYEE NAME (Last) (First) (Middle)			HOME PHONE #		
POSITION		DEPT / DIVISION		CELLULAR #	
HOME ADDRESS (Street) (City) (State) (ZIP)			OTHER #		
2 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 #		
3 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 #		
4 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					
5 ELDER CARE PROVIDER (Optional)					
NAME				PHONE #	
ADDRESS (Street) (City) (State) (ZIP)			OTHER #		
LIST NAME(S) OF INDIVIDUAL(S) BEING CARED FOR BY THIS PROVIDER					
6 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
7 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)					
8 SIGNATURE					
_____			_____		
EMPLOYEE SIGNATURE			DATE		

567 EL CAMINO REAL, SAN BRUNO, CA 94066