

Employee Medical Information Form

Personal Details

- Full Name: _____
- Date of Birth: _____
- Contact Number: _____
- Emergency Contact Name: _____
- Emergency Contact Number: _____

Medical Information

- Blood Group: _____
- Known Allergies: _____
- Chronic Medical Conditions: ☐ Yes ☐ No
 - If yes, specify: _____
- Regular Medications: ☐ Yes ☐ No
 - If yes, specify: _____
- Primary Care Physician's Name: _____
- Physician's Contact Number: _____

Health Insurance Information

- Insurance Provider: _____
- Policy Number: _____
- Coverage Details: _____

Declaration

I certify that the above information is accurate and understand that it will be used only for medical purposes in case of an emergency.

- Employee Signature: _____
- Date: _____