



Park Hill School District

EMPLOYEE INFORMATION SHEET

LAST NAME:	FIRST NAME:	MIDDLE NAME:
ALIASES OR MAIDEN NAME:	HOME PHONE:	CELL PHONE:
ADDRESS, CITY, STATE, ZIP:		
MARITAL STATUS: SINGLE: <input type="checkbox"/> MARRIED: <input type="checkbox"/>	DATE OF BIRTH:	TODAY'S DATE

Are you Hispanic/Latino?

- \_\_\_\_\_ NO, not Hispanic/Latino
- \_\_\_\_\_ Yes, Hispanic/Latino (A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.)

What is your race? (Choose one or more)

- \_\_\_\_\_ **American Indian or Alaska Native** (A person having origins in any of the original peoples of North and South America, including Central America, and who maintains tribal affiliation or community attachment.)
- \_\_\_\_\_ **Asian** (A person having origins in any of the original peoples of the Far East, Southeast Asian, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.)
- \_\_\_\_\_ **Black or African American** (A person having origins in any of the black racial groups of Africa.)
- \_\_\_\_\_ **Native Hawaiian or Other Pacific Islander** (A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.)
- \_\_\_\_\_ **White** (A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.)

EMERGENCY INFORMATION

IN CASE OF EMERGENCY NOTIFY:	RELATIONSHIP:
EMERGENCY CONTACT'S DAYTIME PHONE:	EMERGENCY CONTACT'S CELL PHONE:
PHYSICIAN NAME, ADDRESS, AND PHONE:	
HOSPITAL PREFERENCE:	CPR TRAINED? (Circle One) YES - Exp Date _____ NO

Optional Additional Health Information:

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