Staff Health History 2017

Name: ____

Date of Birth: __________________ Age: __________________ General Health: ____

Emergency Contact: ____ Emergency Contact Phone Number: _______________________________

Relationship to You: ____

Are you currently or have you ever been treated for

Yes	No	Condition	Explain
		Asthma	
		Bleeding Disorders	
		Blood Pressure	
		COPD	
		Diabetes	
		Ear/Sinus	
		Fainting	
		Gastro-Intestinal Problems	
		Hear Disease/Stroke	
		Kidney Disease	
		Learning Disorders	
		Menstrual Problems	
		Musculo-skeletal	
		Psychological/psychiatric	
		Seizures	
		Sickle Cell Disease	
		Sleep Disorders	
		Surgery	
		Thyroid Disease	
		Serious Injury	
		Other	

List all medications you are currently taking, include over-the-counter drugs and herbal supplements

Medication	Dosage	Reason

Allergies:

____

____

Signature:____

If a minor – signature of parent/guardian:

____