 **Staff Health History 2021**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ General Health: ­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to You: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I am fully vaccinated against COVID-19 (circle one) YES NO

**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 |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
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**Allergies:**

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**­­­­­­­­­­Signature:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If a minor – signature of parent/guardian:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_