Staff Health Record

Name: _____ Male Female

Date of birth: _____ Phone: _____

Address: _____

Emergency Contact: _____

Relationship to Staff: _____

Emergency Contact Phone: _____

T-shirt Size: _____

Insurance Company & Policy Number: _____

_____

Medications needed or used:				
Purpose	Kind	Frequency	Dosage	Currently Given Yes/No

Are immunizations up to date? Yes or No TB Test Date: _____ Results _____

Allergies:

_____

_____

Do you have any activity restrictions? _____

I certify that this information is true to the best of my knowledge

_____ Date: _____

Signature