Staff Annual Health Questionnaire

(To be completed by all operators and placed in file once per year)

Full Name: _____

Home Address: _____

Telephone Number: _____

Health Status

1. I am in excellent mental and physical health and am free of communicable disease. (If not, please explain)

_____
_____
_____

2. I take the following medications regularly (please explain).

_____
_____
_____

This health statement is accurate to the best of my knowledge. I will advise the child care consultant if my health status .

Signature _____Date_____

EMERGENCY INFORMATION ON STAFF

Name: _____

Address: _____

Name of Doctor: _____ Phone: _____

Hospital Preference: _____ Phone: _____

Name of Dentist: _____ Phone: _____

To avoid any adverse drug reaction during an emergency, please list medications you are taking:

_____

_____

Allergies: _____

Blood type, if known: _____

List of operations or hospitalizations in the past year: _____

_____

List chronic medical problems requiring a doctor's care: _____

_____

Emergency contact persons:

Name: _____Relationship: _____
Address, if different: _____
Home phone: _____ cell: _____
Name: _____Relationship: _____
Address, if different: _____
Home phone: _____ cell: _____