

**STAFF/VOLUNTEER HEALTH HISTORY**

Staff Member's/Volunteer's Name: \_\_\_\_\_

**The following information is required:**

Emergency Contact Person: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

HEALTH INFORMATION:

1. Are there any health problems including physical, psychiatric, or behavioral problems of which we need to be aware?       NO

YES, Explain: \_\_\_\_\_

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

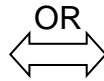
2. Are there any medications, dietary restrictions, allergies, or special needs of which we need to be aware?       NO

YES, Explain: \_\_\_\_\_

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

IMMUNIZATION INFORMATION:

For staff members/volunteers who reside **within** the United States, a United States territory, or the District of Columbia:



For staff members/volunteers who reside **outside** the United States, a United States territory, or the District of Columbia:

1. State/territory in which person resides:

\_\_\_\_\_

2. Is this person exempt from any immunizations?       NO

YES, List them: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

1. Country in which person resides:

\_\_\_\_\_

2. Attach Department form DHMH-896 (record of vaccination or immunity)

Staff Member/Volunteer Signature or

Date

Parent or Legal Guardian's Signature (If Staff Member is Under 18 Years)