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: ______________________________

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

   ☐ YES, Explain: ______________________________

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IMMUNIZATION INFORMATION:

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

1. State/territory in which person resides:

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2. Is this person exempt from any immunizations? [ ] NO
   [ ] YES, List them: ______________

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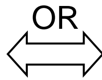
OR



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

1. Country in which person resides:

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

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