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:

1. State/territory in which person resides: __________________________________________

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

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: __________________________________________

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)

DHMH-4767 (01/2015)