Revised 7.09

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 OPERATIONS OR HOSPITALIZATIONS WITHIN THE PAST YEAR: _____

_____

LIST CHRONIC MEDICAL PROBLEMS REQUIRING A DOCTOR'S CARE: _____

_____

EMERGENCY CONTACT PERSONS:

NAME: _____ RELATIONSHIP _____

ADDRESS: _____

HOME PHONE: _____ BUSINESS PHONE: _____

NAME: _____ RELATIONSHIP _____

ADDRESS: _____

HOME PHONE: _____ BUSINESS PHONE: _____

STAFF HEALTH QUESTIONNAIRE

IMPORTANT — Current health information must be completed annually by:
All staff (including the director). (2) All volunteers* and substitutes* prior to their coming into contact with the children.

NAME: _____

HOME ADDRESS: _____

TELEPHONE NUMBER: _____

HEALTH STATUS:

1. I am in excellent mental and physical health and am free of communicable disease. (If no, 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 director if my health status changes.

Signature: _____ Date: _____

_____

*Any substitute or volunteer who is counted in the mandatory staff-child ratio must comply with the health standards for staff.