EMPLOYEE HEALTH EVALUATION

Name: _____ Social Security Number: _____
Address: _____ Phone Number: _____
Job Title: _____ Family Physician: _____
Phone Number: _____
Emergency Contact: _____ Relationship: _____
Address: _____ Phone Number: _____
Do you have any allergies to (*circle all that apply*):

A. Latex or vinyl B. Chemicals/household products C. Soaps/personal care products
D. Foods E. Pollens/dusts F. Certain types of clothing/gloves

Check the box that describes the communicable diseases, vaccinations, or antibody titers you have had. Please include the date(s) of vaccinations or titer completion.

Disease yes/no	Vaccine yes/no	Date	
☐ ☐	☐ ☐	_____	Rubeola (red measles - 7 day)
☐ ☐	☐ ☐	_____	Rubella (German measles - 3 day)
☐ ☐	☐ ☐	_____	Mumps
☐ ☐	☐ ☐	_____	Hepatitis B
☐ ☐	☐ ☐	_____	Chicken Pox
☐ ☐	☐ ☐	_____	Tetanus/Diphtheria
☐ ☐	☐ ☐	_____	Polio
☐ ☐	☐ ☐	_____	Pneumococcal
☐ ☐	☐ ☐	_____	Tuberculosis

If you have had a positive TB skin test, date of skin test conversion: _____
Last chest X-ray date: _____ Result: _____

Please note that if you are pregnant or planning pregnancy, please discuss the occupational risks peculiar to your position (such as exposure to communicable diseases, exposure to cleaner/ disinfectant fumes, lifting) with your physician.

If you have any conditions that may prevent you from performing assigned duties satisfactorily, these must be discussed with your employer. All information will be kept confidential.

The information on this health evaluation is complete and accurate to the best of my knowledge. I hereby certify that I am free of any physical, mental, or emotional condition that would be detrimental to the well-being of those in my care.

_____ _____
(Signature) (Date)