EMPLOYEE HEALTH RECORD

Name_____ Date_____

Family Physician _____ DOB_____

Put an X on the line if you have had any of the following:

Diabetes_____
Fractures_____
Head Injury_____
Back Injury_____
Chronic back pain_____
Tuberculosis_____
Heart trouble_____
Stomach trouble_____
Fainting spells_____
Epilepsy_____
Mental disease_____
Jaundice_____
Rheumatism_____
Asthma_____
Hernia_____

*Operations_____Please list_____
_____
_____
_____

*Other injuries-Please list_____
_____
_____
_____

*Any other chronic health problems_____
_____

*Requires a response

I have read the above and declare that I have had no injury, illness or ailment than as specifically herein noted. Any falsification or misrepresentation will be sufficient grounds for release from employment.

Signature_____
(employee)

4007-R1

Adopted 11-21-02
Revised 3-27-13
Revised 12-21-16
Revised 4-28-21