Knowlton Township Elementary School
Health History
(For Faculty)

Name: _____ Birthdate: _____

Social Security#: _____ Phone#: _____

Address: _____

Family Physician: _____ Phone#: _____

Emergency Contact Person: _____

Home Phone#: _____ Work Phone#: _____

Blood Type: _____ Last Tetanus Booster: _____ Hep. B Vaccine: _____

Allergies: _____

Medication allergies: _____

Asthma: Yes ___ No___ Routine Asthma medications: _____

Cardiac disease: Yes___ No ___ High Blood Pressure: Yes___ No___ Dizziness/Fainting: _____

Diabetes: Type I _____ Type II _____ Diabetes medication/s: _____

Ear or hearing problems: Yes_____ No ____ Eye or vision problems: Yes _____ No _____

Glasses: Yes____ No _____ Contact lenses: Yes ____ No ____

Seizure Disorder: Yes _____ No ____ Medications: _____

Headaches: Migraine _____ Sinus _____ Cluster type _____ Medications: _____

Injuries requiring hospitalization: _____ Date: _____

Musculoskeletal problems: _____

Upper Respiratory infections: Colds ____ Pneumonia _____ TB ____ Other: _____

Date of last Mantoux test: _____ Results: _____

Other health problems or concerns: _____

_____

List all medications, including over the counter medications, you are presently taking: _____

_____

The School Nurse may have a copy of this form (please initial) Yes _____ No _____

Employee signature: _____ Date: _____

NOTE: All information is confidential and will only be used in case of emergency.