Hasbrouck Heights Public Schools
Staff's Health History

Name:_____ Date:_____

Do you, or have you ever had any of the following?

Food Allergies:	Yes	No
Do you have Epi Pen?	Yes	No
Do you have a medical alert bracelet?	Yes	No
Please list to which foods:		
Asthma	Yes	No
Blood Disorders	Yes	No
Diabetes	Yes	No
Seizures	Yes	No
Heart Conditions	Yes	No
High Blood Pressure	Yes	No
Kidney Disease	Yes	No
Lung Disorder	Yes	No

Other:_____

_____

Do you have any allergies to medications? If yes, please list.

_____

Do you take medication on a daily basis? If yes, please list.

_____

_____

The information provided is true to the best of my knowledge.

Employee Signature:_____ Date:_____