

Kingsway Regional School District

EMPLOYEE HEALTH HISTORY

DATE: _____ DATE OF BIRTH: _____

NAME: _____
Last First M

ADDRESS: _____
Street City State Zip Code

PHONE: H () _____ OCCUPATION: _____
C () _____ FAMILY DR.: _____

PERSON TO NOTIFY IN CASE OF EMERGENCY: _____
Name Relationship

PHONE (H) () _____
PHONE (C) () _____

Accidents (Serious) _____ Date _____

Allergies (Pollens, drugs) _____ Asthma _____

Blood Type _____ Unknown _____ Diabetes _____

Convulsive Disorder _____ Earaches _____ Eye Problems _____

Fainting Spells _____ Frequent Colds _____ Headaches _____

Heart Condition _____ High Blood Pressure _____

Hernia _____ Kidney Disease _____

Inoculations: Date of Series of Tetanus Toxoid and/or Booster: _____

Operations (Serious) _____ Date _____

Orthopedic Defects _____

Rheumatic Fever _____

Are you a Positive Tuberculin Reactor? Yes No

List Any Other Health Problems You May Have. _____

Applicant Signature Date