Richland-Bean Blossom Community School Corporation

Employee Health Form

Employee/Substitute Name: _____

Address: _____

In Case of Emergency Please Notify

Primary Contact:

Name: _____

Place of Employment: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Secondary Contact:

Name: _____

Place of Employment: _____

Cell Phone: _____ Work Phone: _____

Health Information

Primary Physician: _____

Phone Number: _____ Address: _____

Ethnicity – Check all that apply:

- ☐ American Indian/Alaskan Native
- ☐ Black
- ☐ Asian
- ☐ Hispanic Ethnicity and of any race
- ☐ White
- ☐ Native Hawaiian or Other Pacific Islander

Please list any medication to which you are allergic: _____

_____

Please list any medication you are currently taking: _____

_____

Please list any health issues you have that the nurse will need to know in case of an emergency:

_____

Do we have permission to transport you to IU Health Bloomington Hospital? ☐ YES ☐ NO

Do you have a religious or philosophical objection to any treatment? ☐ YES ☐ NO

Blood Type: _____

I understand the confidentiality of this information will be maintained unless otherwise specified.

Employee Signature: _____ Date: _____