HEALTH RECORD FOR STAFF IN OASIS PROGRAMS

NAME OF PROGRAM _____

_____ _____ _____ M □ F □

LAST NAME FIRST NAME BIRTHDATE SEX

Home Address: _____ Phone: _____

Parent/Guardian/Spouse: _____ Phone: _____

In case of emergency, notify: _____ Phone: _____

Additional Emergency Contacts:

1. _____ Phone: _____

or 2. _____ Phone: _____

HEALTH HISTORY: (Check all that apply, giving approximate dates)

□ Rheumatic Fever _____
□ Seizures _____
□ Diabetes _____
□ Asthma _____
□ Chicken Pox _____

□ Hay Fever _____
□ Poison Ivy, etc. _____
□ Insect Stings _____
□ Penicillin _____
□ Other Drugs _____
□ Food _____

Illnesses_____
Operations_____
Hospitalization_____

Restricted Activity_____
Appliances Worn_____
Other Conditions_____

PHYSICAL EXAM RESULTS (To be completed and stamped by a Physician)

On the basis of my findings and on my knowledge of the above-named individual, I find that:

- He/she is currently not exhibiting signs or symptoms of a communicable disease that could be transmitted while working with children.

  YES (symptom free) ☐ NO (NOT symptom free) ☐

- He/she is currently not exhibiting signs or symptoms suggestive of an emotional or psychological disorder that would hinder his/her ability to care for children.

  YES (symptom free) ☐ NO (NOT symptom free) ☐

- He/she is physically fit to supervise children and perform the duties required of him/her in the direct supervision of children.

  YES (symptom free) ☐ NO (NOT symptom free) ☐

Date of Exam: _____

Physician Name:
_____

Physician Signature:
_____

Phone #:_____

Business Name: _____

CONSENT FOR EMERGENCY MEDICAL TREATMENT

I do hereby give authority to the Oasis Children's Services to obtain necessary emergency medical treatment for me with the understanding that the family will be notified as soon as possible.

Print Name _____ Signature _____ Date_____