CENTRAL PIEDMONT
COMMUNITY COLLEGE

Revised 7.09

EMERGENCY INFORMATION ON STAFF

NAME: _____

ADDRESS: _____

NAME OF DOCTOR: _____ PHONE: _____

HOSPITAL PREFERENCE: _____ PHONE: _____

NAME OF DENTIST: _____ PHONE: _____

To avoid any adverse drug reaction during an emergency, please list medications you are taking:

_____

ALLERGIES:

_____

BLOOD TYPE (If known.)

_____

LIST OPERATIONS OR HOSPITALIZATIONS WITHIN THE PAST YEAR:

_____

LIST CHRONIC MEDICAL PROBLEMS REQUIRING A DOCTOR'S CARE:

_____

EMERGENCY CONTACT PERSONS:

NAME: _____ RELATIONSHIP _____

ADDRESS: _____

HOME PHONE: _____ BUSINESS PHONE: _____

NAME: _____ RELATIONSHIP _____

ADDRESS: _____

HOME PHONE: _____ BUSINESS PHONE: _____

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STAFF HEALTH QUESTIONNAIRE

IMPORTANT — Current health information must be completed annually by:
All staff (including the director). (2) All volunteers* and substitutes* prior to their coming into contact with the children.

NAME: _____

HOME ADDRESS: _____

TELEPHONE NUMBER: _____

HEALTH STATUS:

1. I am in excellent mental and physical health and am free of communicable disease. (If no, please explain.)

_____

2. I take the following medications regularly (please explain):

_____

This health statement is accurate to the best of my knowledge. I will advise the director if my health status changes.

Signature: _____ Date: _____

* Any substitute or volunteer who is counted in the mandatory staff-child ratio must comply with the health standards for staff.