Newton County School District Employee Health Form

Employee Name: _____ School Year: _____
Date of Birth: _____ Age: _____ Male/Female
Full Address: _____
Phone Number: _____ Email: _____

Emergency Contacts:
Name: _____ Relationship: _____ Number: _____
Name: _____ Relationship: _____ Number: _____

Medical Information:
Primary Physician: _____ Number: _____
Health Insurance: _____ Policy Number: _____
Allergies: (please list all allergies- foods, medications, etc.)
_____
_____
Medications: (please list all medications by name & dosage)
_____
_____
Health History: (please list any major illness, accidents, or surgeries with the year of occurrence)
_____
_____
Please check if you have been diagnosed with any of the following health conditions:

_____ Allergies
_____ Anxiety
_____ Asthma
_____ Bleeding Disorder
_____ Bone/Joint Disease
_____ Cancer
_____ Depression
_____ Diabetes
_____ GI Disorder (stomach/colon)
_____ Heart Disease
_____ Headaches
_____ Hepatitis
_____ Hypertension
_____ Kidney Disease
_____ Lung Disease
_____ Pregnant
_____ Seizures
_____ Stroke
_____ Thyroid Disorder
_____ Vision Problems (Glasses/Contacts)

Other health conditions: