

# HAUNTED HYDRO EMPLOYEE MEDICAL HISTORY FORM

PLEASE PRINT

NAME \_\_\_\_\_ AGE \_\_\_\_\_ D.O.B. \_\_\_/\_\_\_/\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_ ZIP \_\_\_  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL \_\_\_\_\_

## IN CASE OF EMERGENCY NOTIFY:

NAME \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_ ZIP \_\_\_  
HOME PHONE \_\_\_\_\_ WORK PHONE \_\_\_\_\_ CELL \_\_\_\_\_

## HEALTH HISTORY

DATE OF LAST TETANUS \_\_\_/\_\_\_/\_\_\_

### HAVE OR SUBJECTED TO: (CHECK IF YES)

ASTHMA \_\_\_\_\_ FAINTING \_\_\_\_\_ CONVULSIONS \_\_\_\_\_ DIABETES \_\_\_\_\_ HEART \_\_\_\_\_  
ALLERGIES/ Medical Allergies: \_\_\_\_\_  
OTHER(DESCRIBE) \_\_\_\_\_

### HAVE DIFFICULTY WITH (CHECK ALL THAT APPLY)

No Current Medications       No Current Medical Conditions

EYES \_\_\_\_\_ EARS \_\_\_\_\_ NOSE \_\_\_\_\_ THROAT \_\_\_\_\_ LUNGS \_\_\_\_\_ DIGESTION \_\_\_\_\_ NONE \_\_\_\_\_

MEDICATIONS/DOSE/TIMES \_\_\_\_\_  
WHERE WILL MEDICATION BE LOCATED \_\_\_\_\_

### Optional

MEDICAL INSURANCE CO. \_\_\_\_\_ POLICY \_\_\_\_\_

### **AUTHORIZATION OF MEDICAL TREATMENT / STATEMENT OF MEDICAL HISTORY**

THIS HEALTH HISTORY IS CORRECT SO FAR AS I KNOW. IN THE EVENT OF AN EMERGENCY, I HEREBY GIVE PERMISSION TO THE EMT ON SITE, PARAMEDICS, EMERGENCY ROOM OR ANY OTHER EMERGENCY PERSONAL OR PHYSICIAN'S, TO TREAT, HOSPITALIZE AND PERFORM MEDICAL SERVICES IF I AM UN-ABLE TO MAKE DECISIONS.

SIGNATURE \_\_\_\_\_ DATE \_\_\_/\_\_\_/\_\_\_

*Employee Must Sign here! (If under 18, have a parent/guardian sign)*

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**(DO NOT WRITE BELOW THIS LINE)**

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SIGNATURE \_\_\_\_\_ DATE \_\_\_/\_\_\_/\_\_\_

Russ Aikman, EMT (Return this Form to Russ!!)

*This form is for Assistance in the Event of a Medical Emergency. The HIPPA (Health Information Privacy Practices Act) policy is enforced at the Hydro and no medical information shall be shared with anyone with out written consent of the employee.*