OSSE
DC Office of the State Superintendent of Education

## CHILD DEVELOPMENT FACILITY EMPLOYEE HEALTH INFORMATION

**(Print or type)**

**Facility:** _____

**Address:** _____
Street City State/Zip Code

**Telephone:** _____
Area code

**Employee Name:** _____

**Date of Birth:** _____

**Employee Address:** _____
Street City State/Zip Code

**Home Telephone:** _____
Area code

**Known Allergies:** _____

**Physician:** _____ **Telephone:** _____
Area code

**Address:** _____
Street City State/Zip Code

**Person to be contacted in an emergency:**

**Name:** _____ **Relationship:** _____

**Address:** _____
Street City State/Zip Code

**Telephone:** _____
Area code

**I have** ☐ **I have no** ☐ **health insurance (check one).**

**Health Insurance Company:** _____

**Insurance Coverage:** _____

**Employee's Signature:** _____ **Date:** _____

**PLEASE RETAIN A COPY FOR YOUR RECORDS**