EMPLOYEE HEALTH EVALUATION

**Name\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Job Title: ***CAREGIVER.*** Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies to (*circle all that apply*):

|  |  |  |
| --- | --- | --- |
| A. Latex or vinyl | B. Chemicals/household products | C. Soaps/personal care products |
| D. Foods  G. Animals | E. Pollens/dusts | F. Certain types of clothing/gloves |

Check the box that describes the vaccinations you have had. Please include the date(s) of vaccinations.

|  |  |  |  |
| --- | --- | --- | --- |
| **Disease** | **Vaccine** | **Date** |  |
| **yes/no** | **yes/no** |  |
|  |  |  | Mumps |
|  |  |  | Hepatitis |
|  |  |  | Chicken Pox |
|  |  |  | Tetanus/Diphtheria |
|  |  |  | Polio |
|  |  |  | Tuberculosis |
|  |  |  | **COVID-19** |

**Are you able to lift more than 25 pounds? Yes \_\_\_\_\_ No \_\_\_\_\_**

If you have any conditions that may prevent you from performing assigned duties satisfactorily, these must be discussed with your employer. All information will be kept confidential.

The information on this health evaluation is complete and accurate to the best of my knowledge. I hereby certify that I am free of any physical, mental, or emotional condition that would be detrimental to the well-being of those in my care.

***(Signature) (Date)***