Office of the
State Superintendent of Education

**CHILD DEVELOPMENT FACILITY EMPLOYEE HEALTH INFORMATION**
**(Print or type)**

Facility: ____________________

Address: ____________________

Telephone: ____________________

Employee: ____________________

Date of Birth: ____________________

Employee Address: ____________________

Home Telephone: ____________________

Known Allergies: ____________________

Physician: ____________________ Telephone: ____________________

Address: ____________________

Person to be contacted in an emergency:

Name: ____________________ Relationship: ____________________

Address: ____________________

Telephone: ____________________

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

Health Insurance Company: ____________________

Insurance Coverage: ____________________

Employee's Signature: ____________________ Date: ____________________

**PLEASE RETAIN A COPY FOR YOUR FILES**