Atlantic County Office of Workforce Development
"ALLERGY / HEALTH QUESTIONNAIRE"

APPLICANT NAME: _____

PROVIDE A NAME, ADDRESS, AND TELEPHONE NUMBER OF A RELATIVE, FRIEND OR NEIGHBOR THAT BE CONTACTED IN CASE OF EMERGENCY.

NAME: _____

ADDRESS: _____

PHONE #:_____

DO YOU HAVE ANY OF THE FOLLOWING?

ALLERGIES TO	**CHRONIC OR RECURRING ILLNESSES**
HAY FEVER:_____	HEART DISEASE:_____
ASTHMA:_____	CONVULSIONS:_____
MEDICATION:_____	DIABETES:_____
INSECT BITES:_____	PHYSICAL HANDICAP:_____
FOOD REACTIONS:_____	OTHER:_____

Have you had any operations or injuries that would impair your performance in the workplace or in the classroom?
YES_____NO_____
If yes, provide us with (1) nature of illness (2) operation/injury (3) Name of Physician and/or hospital (4) dates of operation/injury.
_____

_____

Please list any medications you are currently taking:
_____

DISCLOSURE STATEMENT:

I_____ VOLUNTARILY GIVE PERMISSION TO UTILIZE THE INFORMATION GIVEN ON THIS FORM. I FULLY UNDERSTAND THAT THIS INFORMATION WILL REMAIN CONFIDENTIAL AND WILL ONLY BE UTILIZED TO ASSIST WIA IN HELPING ME SELECT THE BEST SUITABLE EMPLOYMENT AND/OR TRAINING OPPURTUNITIES AVAILABLE TO ME.

_____
Signature/Date

If applicant is 17 years old or younger: The health history is correct and my son/ daughter have permission to engage in all required job activities except as noted by physician.

_____ _____
Signature of parent/guardian Home # Work #