



**DIVISION OF EARLY LEARNING**  
**Licensing and Compliance Unit**

PHONE: (202) 727-1839 • FAX: (202) 741-5304

MAILING ADDRESS: 810 FIRST STREET, NE • 4th FLOOR • WASHINGTON DC 20002

**EMPLOYEE/VOLNTEER 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**