NEBRASKA
Good Life. Great Mission.
DEPT. OF HEALTH AND HUMAN SERVICES

Nebraska Department of Health and Human Services

# HEALTH INFORMATION REPORT

(Individual Completes Part A Only)

## PART A
## INDIVIDUAL INFORMATION

| Name | | Birthdate |
|---|---|---|
| Street Address | City | Telephone |

### Name and Address of Facility for Whom You Work (If other than own home)

| Name of Facility | Street Address | |
|---|---|---|
| City | State | Zip Code |

### INDIVIDUAL HEALTH HISTORY

| MEDICATIONS | List the Medications you are taking |
|---|---|

Are you being treated for/or have you ever been treated for:

Drug Addiction: ☐ Yes ☐ No Alcoholism: ☐ Yes ☐ No Mental Illness: ☐ Yes ☐ No

In general, my mental and physical health is:

Please list the name of your physician, mental health practioner, or drug and alcohol counselor. You are giving DHHS permission to contact the people listed below. All information is confidential

1._____
Dr. Name Address City State Zip Phone

2._____
Dr. Name Address City State Zip Phone

3._____
Dr. Name Address City State Zip Phone

4._____
Dr. Name Address City State Zip Phone

| Signature of Individual<br>**SIGN**<br>**HERE** | Date |
|---|---|

## PART B - HEALTH EXAMINATION
## This section is to be completed by the Medical Practitioner

Blood Pressure Urinalysis

Albumin_____ Sugar_____

Is individual under treatment for Hypertension? ☐ Yes ☐ No

Does individual have any Communicable Disease? ☐ Yes ☐ No

*NOTE TO PHYSICIAN: This person will be caring for children. If individual is on medication, has a blood pressure higher than 160/95, or the above tests read positive or "YES," will this affect the individuals ability to care for children?*

☐ Yes ☐ No

Comments:

Printed Name of Medical Practitioner

| Must be signed by Medical Practitioner<br>**SIGN**<br>**HERE** | Date |
|---|---|