

**Capital Area Public Health Network  
Employee/Household Member Information Form\*\***

**PLEASE PRINT**

Last Name _____	First Name _____	MI _____
Address _____		City _____ State _____ Zip _____
Phone: Home _____	Work _____	Cell _____ E-mail _____

<b>List names of employee and all household members</b>	<b>Date of Birth</b>	<b>*Allergic to any medicine(s) - list name of medicine(s)</b>	<b>*Allergic to any medicine(s) - list name of medicine(s)</b>	<b>*Allergic to any medicine(s) - list name of medicine(s)</b>
<b>TOTALS</b>				

Employee Signature: _____	Date: _____
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**\* If you are unsure of your response listing a medical allergy, please consult with your physician. List only severe or life threatening allergic reactions to medication(s)**

**\*\* To be completed by each employee in advance and retained by the facility.**