



# Gangwish Seed Farms, Inc.

PO Box 530 Shelton, NE 68876

NAME	TODAYS DATE
HOME OR LOCAL ADDRESS	TELEPHONE NUMBER
EMERGENCY CONTACT NAME	EMERGENCY CONTACT TELEPHONE NUMBER
DATE OF BIRTH	CONTRACTOR
PERSONAL PHYSICIAN	PHYSICIAN'S PHONE

## HEALTH HISTORY

Gangwish Seed Farms, Inc. seeks to offer a safe and healthy working environment to its workers. The following questions are asked to help determine the fitness for duty, and to help ensure that any physical and/or mental conditions do not compromise the health and safety of a worker. The information in this form will be kept strictly confidential. It is our hope that by your sharing the following medical information we will be better able to provide a safe working environment.

- Do you have a disability or medical condition that may require adjustment at work to assist you to undertake the job for which you have applied? No \_\_\_ Yes \_\_\_
- Have you had any illness or operation that required hospitalization in the last 12 months? No \_\_\_ Yes \_\_\_
- Have you been unable to work for 2 or more weeks during the past two years because of an injury/illness? No \_\_\_ Yes \_\_\_
- Are you currently under work restrictions from a physician? No \_\_\_ Yes \_\_\_
- Do you have asthma/ emphysema/ chronic cough? No \_\_\_ Yes \_\_\_
- Do you have diabetes/ hypoglycemia? No \_\_\_ Yes \_\_\_
- Have you had seizures? No \_\_\_ Yes \_\_\_
- Have you had any joint/ muscle (ankle, neck, back, shoulder, knee) trouble? No \_\_\_ Yes \_\_\_
- Do you have heart trouble? No \_\_\_ Yes \_\_\_
- Have you experienced heart exhaustion/ heat stroke? No \_\_\_ Yes \_\_\_
- Have you ever been dependent on any drugs, alcohol, or other substances? No \_\_\_ Yes \_\_\_
- Are you receiving treatment for any mental health condition? No \_\_\_ Yes \_\_\_
- List all medications that you take on a routine or occasional basis (including non-prescription medications) :

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- List all allergies (including anaphylaxis, medications, food, latex, corn, soy beans, bee stings, and insects):
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I confirm that the information on this form is correct to the best of my knowledge. I understand if any information is false or has been deliberately omitted, I may be dismissed. I understand that medical details will not be divulged without my permission to any person outside the site's medical department, but an opinion about my fitness to work will be given to management. I agree to an occupational health record being kept recording my health while at work. **Parental signature is required for all minors.**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Parent Signature: \_\_\_\_\_

Date \_\_\_\_\_