



Oradell Public School District

Our children, our hope, our future

ANNUAL EMPLOYEE HEALTH ASSURANCE STATEMENT

2023-2024

Name: _____

Address: _____

Primary Care Physician: _____

Physician Phone Number: _____

Person to be notified in case of emergency: _____

Relationship: _____ Phone Number: _____

1.) Have there been any notable changes (i.e., new allergies, accidents, hospitalizations, major diagnosis) to your health status during the past year? Yes No

If yes, please provide a brief description below:

2.) Are you taking any new medications of which the school nurse should be aware? Yes No
If yes, please make an appointment with the school nurse to discuss.

Please sign the following statement:

To the best of my knowledge, I am fit to perform, with reasonable accommodation, in the position I am currently holding and do not pose any health risk to students and other staff members.

Employee Signature: _____ Date: _____