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|  | | | | | | | | | | | | | | OMB Control Number: 0693-XXXX Expiration Date: ##/##/#### | | | | | | | | | | | | |
| **NIST-986**  **(REV. 4-2018)**  **NIST P 7100.00** | | | | | | | | | | | | | | U.S. DEPARTMENT OF COMMERCENATIONAL INSTITUTE OF STANDARDS AND TECHNOLOGY | | | | | | | | | | | | |
| **HEALTH RECORD** | | | | | | | | | | | | | | | | | | | **Date:** | | | | |  | |  |
|  | | | | | |  |  |
| **The Privacy Act of 1974 (P.L. 93-579) requires that you be given certain information in connection with information solicited. All information listed below is given voluntarily and is confidential. It will be used only by the Health Unit in a medical emergency.** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Name *(Last, first, middle initial)*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Date of Birth** | | | | | | | | | | | **Social Security Number/Passport Number/Driver’s License Number** | | | | | | | | | | | | **Male** | |  | |
|  | | | | | | | | | | |  | | | | | | | | | | | | **Female** | |  | |
| **Work Telephone Number** | | | | | | | | | | | **Email Address** | | | | | | | | | | | | **Mail Stop** | | | |
|  | | | | | | | | | | |  | | | | | | | | | | | |  | | | |
| **Job Title** | | | | | | | | | | | **Division** | | | | **Building** | | | | | | | | **Room** | | | |
|  | | | | | | | | | | |  | | | |  | | | | | | | |  | | | |
| **Supervisor/Sponsor** | | | | | | | | | | | | | | | **Supervisor/Sponsor Telephone Number** | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| **Home Address** | | | | | | | | | | | | | | | **Personal Telephone Number** | | | | | | | | | | | |
|  | | | | | | | | | | | | | | |  | | | | | | | | | | | |
| **Private Physician *(Name, address, telephone number)*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Emergency Contact(s)** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **1.** | **Name:** | |  | | | | | | | | | | | | | **Relationship:** | | | | | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |  |
| **Phone #:** | | | |  | | | | | | | | | | | |  | | | | |  | | | | |  |
| **2.** | **Name:** | |  | | | | | | | | | | | | | **Relationship:** | | | | | **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** | | | | |
| **Phone #:** | | | |  | | | | | | | | | | | |  | | | | |  | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | |  |
|  | | **I give consent to the above named person(s) to access any and all medical information related to me.** | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | **I am the only person authorized to access any and all medical information related to me. (In the case of incapacitation, state/federal laws would take effect.)** | | | | | | | | | | | | | | | | | | | | | | | | |
| **Significant Medical Problems** | | | | | | | | | | | | | **Details** | | **Allergies - non-medication** | | | | | | | | | | | |
| **Arthritis/Chronic Pain**  **Asthma/COPD/Emphysema Other Lung Disorders**  **Cancer**  **Diabetes**  **High Blood Pressure**  **Kidney Disorders**  **Mental Illness/Anxiety/Depression**  **Seizures/Neurological Disorders**  **Stroke/Heart/Cardiovascular Diseases**  **Other:** | | | | | | | | | | | | |  | |  | | | | | | | | | | | |
| **Allergies - medications** | | | | | | | | | | | |
|  | | | | | | | | | | | |
| **Current Medications *(and date started)*** | | | | | | | | | | | | | | | | | | | | | | | | | | |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Chaperone Requested:** | | | | | | | |  | **Yes** |  | | **No** | | | | | | | | | | | | | | |
| **Preferred Pharmacy:** | | | | | | |  | | | | | | | | | | | | | | | | | | |  |
| **Pharmacy Address:** | | | | | |  | | | | | | | | | | | **Phone #:** | | |  | | | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **By signing below, I agree to the following: The above information is correct and true to the best of my knowledge. I have received and understand**  **the Notice of Privacy Practices, Health Unit Rights and Responsibilities, and Chaperone Policy. I have received and understand the Consent for Care and fully consent to treatment.** | | | | | | | | | | | | | | | | | | | | | | | | | | |
| **Signature:** | | | | |  | | | | | | | | | | | | | **Date:** | | | |  | | | |  |
|  | | | | | | | | | | | | | | | | | | | | | | | | | | |

**OMB Control Number: ####-#### Expiration Date: ##/##/####**

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**Privacy Act Statement**

**Authority:**  The collection of this information is authorized under The National Institute of Standards and Technology Act, as amended, 15 U.S.C. 271 et seq. (which includes Title 15 U.S.C. 272) and section 12 of the Stevenson-Wydler Technology Innovation Act of 1980, as amended, 15 U.S.C. 3710a. Includes the following, with all revisions and amendments: 5 U.S.C. 301; 44 U.S.C. 3101; E.O. 12107, E.O. 13164, 41 U.S.C. 433(d); 5 U.S.C. 5379; 5 CFR Part 537; DAO 202-957; E.O. 12656; Federal Preparedness Circular (FPC) 65, July 26, 1999; DAO 210-110; Executive Order 12564; Public Law 100-71, dated July 11, 1987. Executive Orders 12107, 12196, and 12564 and 5 U.S.C. chapters 11, 33, and 63.

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Commerce/DEPT-18:  Employees Personnel Files Not Covered by Notices of Other Agencies

OPM/GOVT-10:  Employee Medical File System Records

**Disclosure:**  Furnishing this information is voluntary.  For Health Unit information collections, individuals have opportunity to decline providing information, however, care may be affected and future retrievability will be impacted. Submitting voluntary information constitutes your consent to the use of the information for the stated purpose. When you submit the form, you are indicating your voluntary consent for NIST to use of the information you submit for the purpose stated.

**NIST-986 (REV. 4-2018)**