OMB Control Number: 0693-XXXX Expiration Date: ##/##/####

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(REV. 4-2018)
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U.S. DEPARTMENT OF COMMERCE
NATIONAL 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**
☐ **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 - non-medication

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: ##/##/####

This collection of information contains Paperwork Reduction Act (PRA) requirements approved by the Office of Management and Budget (OMB). Notwithstanding any other provisions of the law, no person is required to respond to, nor shall any person be subject to a penalty for failure to comply with, a collection of information subject to the requirements of the PRA unless that collection of information displays a currently valid OMB control number. Public reporting burden for this collection is estimated to be 10 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed and completing and reviewing the collection of information. Send comments regarding this burden estimate or any aspect of this collection of information, including suggestions for reducing this burden, to the National Institute of Standards and Technology, Attn: Stephen Banovic, 301-975-8822.

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.

Purpose: The Office of Safety, Health, and Environment (OSHE) supports the National Institute for Standards and Technology in carrying out its mission safely and in maintaining safety as an integral core value and vital part of the NIST culture. The NIST Health Unit will use this information to record medical or health information for individuals seeking medical care on NIST campus; for recording of medical or safety equipment or incidents; to refer information required by applicable law to be disclosed to a Federal, State, or local public health service agency, concerning individuals who have contracted certain communicable diseases or conditions. Such information is used to prevent further outbreak of the disease or condition; to disclose information to the appropriate Federal, State, or local agency responsible for investigation of an accident, disease, medical condition, or injury as required by pertinent legal authority; to disclose information, when an individual to whom a record pertains is mentally incompetent or under other legal disability, to any person who is responsible for the care of the individual, to the extent necessary; to disclose to the Office of Workers' Compensation Programs in connection with a claim for benefits filed. Disclosure of this information is also subject to all the published routine uses as identified in the Privacy Act System of Records Notices:
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.