



STAR ISLAND CORPORATION

Morton-Benedict House · 30 Middle Street · Portsmouth, New Hampshire · 03801

Office: 603-430-6272 · Island: 603-601-0832 · www.starisland.org

Star Island Employee Health Form Cover Sheet

The following health form is designed in a **Self Report** format to make filling out your health record easier for you. To protect your privacy, submit this form in a **separate sealed envelope** marked "**Confidential Health Form.**" Completion of this medical form is a condition of employment.

Star Island is a small island in a remote location with access only by boat. Although there is a first aid station on the island, it is equipped for only basic emergency and first aid treatment & may not be staffed at all times. Travel time to an off island medical facility is a minimum of an hour and may be much longer depending upon weather and sea conditions. There are inherent risks in traveling to and staying on Star Island which cannot be eliminated, such as exposure to elements on a remote island including but not limited to inclement weather, wildlife and unmonitored terrain and woods; the potential for others participating in conference programs to act in a negligent manner that may cause or contribute to injury, harm, or death; and lack of access to a medical facility without extensive travel by boat and motor vehicle.

The Star Island Corporation strongly recommends **not** participating on the staff if you have a medical condition which might reasonably require emergency medical response including but not limited to heart conditions, the last trimester of pregnancy, severe allergic reactions to wildlife or any significant illness/chronic condition which requires ongoing medical treatment or monitoring. If you have had recent surgery or pending, have unstable mental health issues such as panic disorder or bipolar disorder, have neurological problems such as a seizure disorder or mobility issues, if you require specialized medications such as insulin, need specific medical equipment such as oxygen as well as any of the above mentioned conditions, Star Island Corporation is **requiring a medical work clearance from your health care provider** stating you are capable of performing your job responsibilities on Star Island. Employees are also responsible for monitoring & managing their own medical conditions while on the island. Employees need to have an adequate amount of medication for the season as well as be aware of secondary medical issues that may arise as a result of their health condition.

Star Island life can be arduous with many of the jobs physically demanding. The ability of each staff person to attend to his or her routine duties as well as to respond to emergencies is critical. You will be called upon to train as a part of our fire safety team, run short distances in a fire drill or emergency situation and be able to lift a maximum of 50 lbs. You may be required to assume other work duties other than what you were primarily hired for. You need to be capable of living in a small space in a community setting with a limited water supply for hygiene.

You are financially responsible for any *non work* related health care services such as prescriptions, lab work, x-rays that are recommended through the First Aid Station (FAS) with self payment required in full. If you have insurance, your medical service or prescription, called into a mainland pharmacy, may be covered depending upon your plan. Include a **COPY** of the **front & back of your insurance card** with your completed health form

PRIVACY ACT STATEMENT

Principal purposes for which your Medical Information is intended to be used:

1. Establish eligibility to be employed by Star Island Corporation.
2. Establish & maintain a medical record for FAS medical staff use.
3. Allow discussion of pertinent medical information with Star Island Management in the event of injury or medical emergency.
4. Release work related injury information to the Star Island Management for insurance purposes.
5. Discuss work related and/or personal injury information with the Joint Loss Management Committee (Safety Committee) for Island safety review.



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Star Island Self Report Employee Health Form

Employee's Name:		Date of Birth:	
Preferred Name:		Preferred Pronouns:	
Primary Job Position:		Dates of position: ___/___/___ - ___/___/___	
Address:		Phone:	
Who can Star Island notify in case of a serious injury or medical emergency?			
Emergency contact:		Relationship:	
Address:		Phone:	
		Work Phone:	

Medication Allergies: No YES _____

CURRENT PRESCRIPTION AND OVER THE COUNTER MEDICATIONS	DOSES	REASON FOR TAKING

Food/Insect Allergies: No YES _____

Tobacco Use: No Yes How Much? _____ per Day Week Month

Alcohol Use: No Yes How Much? _____ per Day Week Month

Surgery: No Yes _____

Foreign Travel (in the past two years): No Yes Where? _____

Do you have regular health care? Yes No Date of last Physical? _____

Are you physically fit & stable? Yes No _____

Are you capable of lifting up to 50 lbs? Yes No _____

Are you able to run short distances? Yes No _____

Are you able to climb four flights of stairs a day? Yes No _____

Are you mentally & emotionally stable? Yes No _____

Are your Immunizations up to date? Yes No _____

Necessary Date: Last Tetanus/ Diphtheria (Td) or (Tdap) booster: ___/___/___

Have you had 2 MMR vaccines? Yes No _____

Have you had 3 Hepatitis B vaccines? Yes No _____

Have you had a Meningococcal vaccine? Yes No _____

Have you had the Chicken Pox vaccine? Yes No _____

HEALTH PROBLEMS		ANY MEDICATION /TREATMENT NEEDED?
ADD/ADHD	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Allergy Condition	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Anxiety / Depression	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Asthma	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Back pain	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Bipolar Disorder	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Bowel Problems	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Bronchitis	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Chicken Pox	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Cholesterol	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Diabetes	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Eating Disorders	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Headaches	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Heart Condition	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
High Blood Pressure	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Lyme Disease	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Muscle/Bone/Joint Problems	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Panic Disorder	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Pneumonia	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Seizure Disorder	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Sinus Infections	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Skin problems	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Stomach Disorder	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Tropical Diseases	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Urinary Infections	<input type="checkbox"/> Current <input type="checkbox"/> Past	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Other Conditions: _____		

Immunizations Recommended for Wastewater Treatment Facility & Maintenance Dept. Crews.

Hepatitis A vaccine date #1 _____ #2 _____ Need

Hepatitis B vaccine date #1 _____ #2 _____ #3 _____ Need

Last Td/Tdap booster date _____ *Completed series before arrival recommended but FAS will update these 2 crews during open up as needed.*

Do you have health insurance? Yes No _____

Have you included a copy of the front/back of insurance card with this form? Yes

I have read the Health Form Cover Sheet & certify that all the information provided by me is complete & true to the best of my knowledge. I understand that any false or misleading information could result in termination of my employment.

SIGNATURE _____ DATE _____

I authorize the release of my medical information by the First Aid Station Medical Staff to the Island Manager, the Portsmouth Star Island office & the Joint Loss Management Committee as deemed necessary & appropriate in the event of a medical emergency, a serious accident or work related injury.

SIGNATURE _____ DATE _____