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. Completing 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 emergencies 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 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, last trimester of pregnancy, severe allergic reactions, 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 and 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 community setting with a limited water suppl.

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.

Please include a **COPY** of the ***front & back of your insurance card*** with your completed 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 confidential medical record for FAS medical staff use.
3. Authorize the discussion and sharing of pertinent medical information between the undersigned individual and Star Island Management in the event of an injury or medical emergency.
4. Release work-related injury information to the Star Island Management for insurance purposes. Discuss work-related and/or personal injury information with the Joint Loss Management Committee (Safety Committee) for safety review.

Date:

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Name: _____ Preferred Name: _____ Date of Birth: _____

Pronouns: _____ Gender: _____ Sex at Birth:_____ Height:_____ Weight:_____

Job Title: _____ Start & End Date: _____ to _____

Address: _____ Phone: _____

Emergency Contact: _____ *Relationship:* _____

Address: _____ Phone: _____

HEALTH INFORMATION

ALLERGIES: (Medications/Food/Insects/Latex, etc.): _____

Do you carry an epinephrine autoinjector (EpiPen) ____Yes ____No

MEDICATIONS: *List all medications currently taking including over the counter, supplements, etc.*

MEDICATIONS	DOSES	REASON FOR TAKING

IMMUNIZATIONS:

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** _____

★**Wastewater Treatment Facility & Maintenance Department & Crews –The following Immunizations are *STRONGLY RECOMMENDED:***

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.

HEALTH & SOCIAL HISTORY

Surgery: ☐ No ☐ Yes _____

Foreign Travel (in the past year): ☐No ☐Yes Where? _____

Tobacco Use: ☐No ☐Yes How Much? _____per ☐Day ☐Week ☐Month
Alcohol Use: ☐No ☐Yes How Much? _____per ☐Day ☐Week ☐Month
Do you have regular health care? ☐ Yes ☐ No Date of last Physical? _____
Are you physically fit & stable? ☐ Yes ☐ No _____
Are you capable of lifting 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 _____
Do you have health insurance? ☐ Yes ☐ No

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

HEALTH PROBLEMS		**MEDICATION /TREATMENT NEEDED?**
ADD/ADHD	☐ Current ☐ Past	☐ No ☐ Yes_____
Allergy Condition	☐ Current ☐ Past	☐ No ☐ Yes_____
Anemia	☐ Current ☐ Past	☐ No ☐ Yes_____
Anxiety / Depression	☐ Current ☐ Past	☐ No ☐ Yes_____
Autism or other neurodivergent diagnosis	☐ Current ☐ Past	☐ No ☐ Yes_____
Diabetes	☐ Current ☐ Past	☐ No ☐ Yes_____
Heart/Circulatory Conditions: Heart murmur, high or low blood pressure, etc.	☐ Current ☐ Past	☐ No ☐ Yes_____
Lyme Disease	☐ Current ☐ Past	☐ No ☐ Yes_____
Mental Health conditions: (not listed): Bipolar or panic disorder, OCD, eating disorder, etc.	☐ Current ☐ Past	☐ No ☐ Yes_____
Muscle/Bone/Joint Issues: Back or neck pain, arthritis, shoulder dislocation, etc.	☐ Current ☐ Past	☐ No ☐ Yes_____
Neurologic Disorders: Seizure, dizziness, migraines/headaches, traumatic brain injury, etc.	☐ Current ☐ Past	☐ No ☐ Yes_____
Respiratory conditions: Asthma, bronchitis, pneumonia, etc.	☐ Current ☐ Past	☐ No ☐ Yes_____
Sinus Infections/tonsilitis, chronic sore throat:	☐ Current ☐ Past	☐ No ☐ Yes_____
Skin conditions: eczema, psoriasis, chronic skin irritation, etc.	☐ Current ☐ Past	☐ No ☐ Yes_____
Stomach/intestinal disorders: Ulcers, acid reflux, Crohn's, etc.	☐ Current ☐ Past	☐ No ☐ Yes_____
Tropical diseases: Malaria, dengue fever, etc.	☐ Current ☐ Past	☐ No ☐ Yes_____
Urinary/kidney conditions: UTI, kidney stones, etc.	☐ Current ☐ Past	☐ No ☐ Yes_____
Other medical conditions:		

I, the undersigned, hereby acknowledge that I have thoroughly reviewed the Health Form Cover Sheet. I certify that all information I have provided is complete, accurate, and true to the best of my knowledge. I understand that any misrepresentation, omission, or misleading information may result in disciplinary action, including the potential termination of my employment.

Signature: _____ Date: _____

In addition, I hereby authorize the release of my medical information by the First Aid Station Medical Staff to the following parties: Senior Management involved in the coordination of medical care, the Portsmouth Star Island office, and the Joint Loss Management Committee. This authorization is granted for the purpose of ensuring proper medical response in the event of a medical emergency, serious accident, or work-related injury.

Signature: _____ Date: _____