Minnesota Department of Corrections
Community Work Programs

CREW MEMBER MEDICAL INFORMATION SHEET

CREW MEMBER SHOULD COMPLETE THIS FORM BEFORE STARTING FIRST ASSIGNMENT

NAME_____ D.O.B. _____

HOME ADDRESS _____

CITY _____ STATE _____ ZIP _____

TELEPHONE (home) _____ (work) _____

EMERGENCY CONTACT PERSON _____ TELEPHONE _____

To assist in your job or task placement, please check all that apply (if you have had or are now experiencing):

☐ Poison Ivy Allergy ☐ Allergic to Bee Stings ☐ Other Allergies ☐ Diabetes ☐ Frostbite
☐ Fainting/Blackouts ☐ Heart Trouble ☐ Heat Stroke ☐ Asthma ☐ Epilepsy
☐ Now Pregnant ☐ HIV Positive ☐ Hemophilia ☐ Cancer ☐ Back Injury
☐ Other Disability _____

Do you have medical restrictions limiting the work you can do? ☐ Yes ☐ No If yes, please explain:

Please list all current mediations:

Are you currently under a doctor's orders regarding work? ☐ Yes ☐ No If yes, please explain:

Physician: _____ Clinic: _____

Clinic Phone: _____ Do you currently have health care coverage? ☐ Yes ☐ No

Medical Assistance/Insurance Co.: Policy/Account No.:

I understand the medical information I provide will be used to determine suitability for participation in a community work program and may be released to medical professionals in the event of a medical emergency. I understand I must notify the crew leader **immediately** if I am injured while performing work service. I also understand that my health care coverage must pay for medical costs. If I do not have health care coverage or incur costs not covered, I must contact the crew leader within **30 days** of the date of injury to file a claim or I will be fully responsibility for my medical costs. I declare under penalties of perjury that the information provided in this document is true, correct and complete to the best of my knowledge and belief.

Signature: _____ Date: _____

Parent/Guardian: _____ Date: _____

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