



# Health & Wellness Form

**Today's Date:** \_\_\_\_\_ **Anticipated Start/End Dates *\*required*:** \_\_\_\_\_

**Your Name:** \_\_\_\_\_ **Emergency Contact Name:** \_\_\_\_\_

**Email:** \_\_\_\_\_ **Emergency Relationship:** \_\_\_\_\_

**Phone #:** \_\_\_\_\_ **Emergency Email:** \_\_\_\_\_

**Birthday:** \_\_\_\_\_ **Emergency Phone #:** \_\_\_\_\_

All incoming staff (short-term volunteers, long-term volunteers, employees and contractors) are required to complete this form once per calendar year. Please complete this form with honesty and accuracy, to the best of your knowledge. This form will only be shared with the Holden Village Medic or Medical Director, who will give their recommendation to the Staffing Committee if deemed necessary.

Holden Village is located in the wilderness and we are neither prepared nor equipped to provide ongoing primary health care. We make every effort to have a medic available for first aid/emergency care, but there may not always be licensed medical personnel onsite. Prompt evacuation is not always possible. Careful planning and prevention on your part is necessary: Holden Village is at least 4 hours (and in the winter up to 4 days) from emergency medical care.

Holden Village asks about certain health issues out of respect for the needs of each individual and for the needs of the Village. Past medical history (with physical and/or mental health concerns) does not restrict you from volunteering; however, your openness to discussing these issues helps Holden know how to best address any health concerns that may arise if you reside in the Village. We ask these questions so that we can understand your needs and so that you can learn about the support Holden is able to offer you and what is beyond our ability to support.

**Current Health Status of Holden Village:** *Holden Village is committed to promoting the health of all members of our society; thus we practice public health measures and the science of health and wellness. As a part of this commitment, we require a record of immunization for tetanus, COVID-19 (ages 5 and older), chicken pox, and measles, mumps and rubella (MMR).*

## Allergies - Please describe any medication or environmental allergies:

Have you ever had a systemic allergic reaction to bee stings or food? If yes, what was the precipitating substance or reaction? What was the treatment?

## Immunizations

◆ COVID-19 #1 <i>*required</i>	<input type="checkbox"/> Moderna	<input type="checkbox"/> Pfizer	<input type="checkbox"/> Janssen	<b>Vaccine Date:</b>
◆ COVID-19 #2 <i>*required</i>	<input type="checkbox"/> Moderna	<input type="checkbox"/> Pfizer	<input type="checkbox"/> Janssen	<b>Vaccine Date:</b>
◆ COVID-19 Booster	<input type="checkbox"/> Moderna	<input type="checkbox"/> Pfizer	<input type="checkbox"/> Janssen	<b>Vaccine Date:</b>
◆ Measles, Mumps & Rubella (MMR) <i>*required</i>	I had M/M/R at age: _____			If no, <b>Vaccine Date:</b>
◆ Chicken Pox Vaccine <i>*required</i>	I had Chicken Pox at age: _____			If no, <b>Vaccine Date:</b>
◆ Tetanus (TdaP)				

*\*required in last 5 years for stays including months of Oct 15 - May 1 due to remote location/limited access*  
*\*required in last 10 years for stays during months of May 1-Oct 15* **Date of last TdaP or booster:** \_\_\_\_\_

**Health History** - Please describe your health history related to the following: anemia, anxiety, arthritis, asthma/COPD blood pressure issues, cancer, depression, diabetes, eating disorders, GI issues, heart issues, low blood sugar, migraines/headaches, seizures, sleep issues, stroke, hospitalizations in the last 12-months, or other:

**Health Condition** - Briefly describe your general state of health as you perceive it:

**What medications are you currently taking?**

**Mental Health History** *Completion of the Mental Health History section is encouraged for all, but only required by individuals submitting applications for long-term volunteer or employee positions.*

**Have you ever had individual, family or group counseling/treatment for personal growth or for emotional/psychological concerns? Please comment on your reasons for counseling/treatment, any medication prescribed, length of treatment, and the impact of treatment.**

**Have you ever received a mental health diagnosis from a mental health professional? If yes, please explain and please comment on your plans for self-care and treatment while you are working and living in the Village.**

**Have you experienced suicidal ideation? If yes, please explain and please comment on your plans for self-care and treatment while you are working and living in the Village.**

**Sometimes the Holden medics or directors ask staff to seek counseling if they display unhealthy behavior or if their behavior negatively affects work or community. How would you respond if asked to seek counseling?**

## Acknowledgement

- I understand the remote nature of Holden Village and its limitations to health care.
- I release this information to be used by Holden Village as needed to ensure safety.
- If I have severe allergies, I will bring my own EpiPen or Bee Sting Kit.

**SIGNATURE**

**PRINTED NAME**

**DATE**

***Please save & email this form to [medic@holdenvillage.org](mailto:medic@holdenvillage.org),  
OR return form to Holden Village Medic, HC0 Box 2 Chelan, WA 98816***