BELLS

"THE AGENCY THAT CARES"
90-50 PARSONS BLVD, SUITE 207, JAMAICA, NY, 11432
TELEPHONE: (718) 297-4446 FAX (718) 297-4449

EMPLOYEE HEALTH EXAMINATION

- **Note: This form must be completed in its entirety in order to be accepted by the agency.**

Date of Exam: _____

Employee Name:_____ **Telephone #:** _____

Address: _____

Sex: _____ **Date of Birth** _____ **Height:** _____ **Weight:** _____

History
Tuberculosis: Yes _____ **No** _____

Other Previous Medical History:

_____
_____
_____

Habituation/Addiction: Yes _____ **No** _____

If Yes, please explain:

_____
_____
_____

Health Status:

Skin		**Heart**	
Head & Neck		**Lungs**	
Eye		**Abdomen**	
Ear		**Back**	
Nose		**Extremities**	
Oral Cavity		**Reflexes**	
Chest			

Is Employee free from communicable diseases? **Yes**_____**No** _____

Is Employee free from health impairments that would present a risk to the residents of the facility that cannot be reasonably accommodated? **Yes**_____ **No**_____

Can Employee perform job related functions? **Yes**_____ **No** _____

If No to any of the above, please specify:

_____
_____
_____

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Employee Name: _____

Date of Exam: _____

TB SCREENING QUESTIONNAIRE		
1	Have you ever had a test for TB?	
2	If you have had a TB test, please specify the PPD test date?	
3	If you have had a TB test, please specify the PPD test results and mm of induration if known?	
4	If you have had a TB test, please specify the Chest X-ray test date?	
5	If you have had a TB test, please specify the Chest X-ray test result?	
6	Do you have any of the following symptoms? Cough in the past 24 hours, fever, Night sweats, weight loss	
7	What color is your sputum (if present)?	
8	Have you ever been exposed to anyone exhibiting the above signs or symptoms, or someone who has had an active TB?	
9	If you have been exposed and received treatment, what type of treatment did you receive?	
10	If you received treatment, for how long?	
11	Have you ever had cancer of the head, neck or lung, leukemia or lymphoma?	
12	Have you ever had an organ or tissue transplant?	
13	Are you taking steroids, chemotherapy or drugs that affect your immune system?	
14	Do you have diabetes or high blood sugar?	
15	Do you have renal failure or are you on kidney dialysis?	
16	Do you think you are at risk for having HIV infection?	
17	Have you ever injected street drugs?	
18	Were you born outside of the United States?	
19	If you were born outside of the United States, where?	
20	Have you travelled to any other country recently for more than (1) month?	
21	If you travelled recently, to where?	
22	Have you ever lived or worked in a group setting such as a hospital, nursing home, drug treatment center, homeless shelter, jail or prison?	

I have conducted a Tuberculosis Screening Questionnaire on the above referenced employee. This includes a review of symptoms which may be indicative of a possible tuberculosis infection. I have also assessed the employee for other associated risk factors which may predispose him/her to a possible tuberculosis exposure. The results of the Tuberculosis Screening Questionnaire are documented in the final Employee Health Examination Report.

Name of Doctor/Nurse: _____

Signature of Doctor/ Nurse: _____

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Employee Name: _____

Date of Exam: _____

P.P.D (Mantoux):

Date administered_____Date read _____

Results (48-72 hours after date taken)_____Induration_____MM

Second P.P.D (administered at least 1-3 weeks after first P.P.D):

Date administered_____Date read _____

Results (48-72 hours after date taken)_____Induration_____MM

- **Note:** Time test not sufficient. If P.P.D is negative, P.P.D test must be repeated every year at time of annual physical.
- **Note:** Chest X-Ray is required if P.P.D is positive.

Chest X-ray: Date examined:_____Results:_____**(Please attach copy of Chest X-ray results. Chest X-ray should be repeated each year if P.P.D result is positive.)**
Recommendation:_____

_____

_____

IMMUNIZATION VACCINES THAT ARE RECOMMENDED BY NEW YORK STATE DEPARTMENT OF HEALTH FOR PERSONNEL: INFLUENZA, HEPATITIS B, DIPHTHERIA, TETANUS, PNEUMOCOCCAL. I CERTIFICATE OF IMMUNIZATION AGAINST MEASLES ONLY REQUIRED FOR EMPLOYEES BORN ON AND AFTER JANUARY 1, 1957.

Name	Date	Name	Date
Influenza Vaccine		Pneumococcal Vaccine	
Hepatitis B Vaccine		Measles Vaccine	
Diphtheria Vaccine		Tetanus Vaccine	
Rubella Vaccine		Varicella Vaccine	

(Please attach copy of immunization lab results)

Urine Toxicology Screening (via chain of custody) Results_____
(Please attach copy of results for drug test, should be 8-10 panel)

To be completed by Physician:

M.D. Name: _____
(Print Name)
M.D. Signature: _____
M.D. License #: _____
Address: _____
(Please Use Company Stamp If Available)
Telephone #: _____
Date of exam: _____

To be completed by Agency Personnel:
Faculty Signature:_____
Date reviewed:_____

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Employee Name: _____

Date of Exam: _____

HEPATITIS B VACCINE PROGRAM

Please check one of the following, then sign and date:

- o I do not wish to be given the Hepatitis B Vaccine at this time. I am aware that I may request to be provided the vaccine at a later date during my employment with the agency.
- o I have already received the Hepatitis B Vaccine series.

Signature:_____ **Date:** _____

- o I am requesting to receive the Hepatitis B Vaccine. (complete consent below)

HEPATITIS B VACCINATION CONSENT

I,_____, have been provided with information on the Hepatitis B vaccine and have been evaluated by an agency health professional. I have had the opportunity to ask questions about the benefits and risks of Hepatitis B Vaccination. I also understand that there is no guarantee that I will become immune and that there is a possibility that I will experience an adverse side effect from the vaccine.

- o I am **NOT allergic** to yeast or yeast products.
- o I am **NOT currently immunosuppressed**, neither by disease or medication.

  For women: I have been advised that studies have not been conducted to determine the effect of the vaccine on a developing fetus. Therefore, the safety of the Hepatitis B vaccine relating to the developing fetus is currently unknown.

Employee Signature:_____ **Date:** _____

Witness Signature:_____ **Date:** _____