MAIN: 40-04 JUNCTION BLVD. CORONA, NY 11368
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CDPAP

PHYSICAL EXAMINATION REPORT

NAME:	DOB:	SSN (Last 4):
ADDRESS:	PHONE:	

	COMMENTS		COMMENTS
HEAD		ABDOMINAL	
EYES		EXTREMITIES	
NECK		CARDIOVASCULAR	
THROAT		MUSCULOSKELETAL	
LUNGS		SKIN	
HEART		CENTRAL NERVOUS SYSTEM	

HT:	WT:	B/P:	PULSE:	RESP:	TEMP:

REQUIRED FOR PRE-EMPLOYMENT

RUBELLA LABS REQUIRED	DATE:	TITER: ☐ IMMUNE ☐ NON-IMMUNE	**MMR VACCINE DATES:** MMR 1:
RUBEOLA (MEASLES) LABS REQUIRED	DATE:	TITER: ☐ IMMUNE ☐ NON-IMMUNE	MMR 2:

PPD	1. Date Implanted:	2. Date Read:	RESULTS (MM): ☐ NEGATIVE ☐ POSITIVE
QUANTIFERON LABS REQUIRED	DATE:	RESULTS: ☐ NEGATIVE ☐ POSITIVE	
CHEST X-RAY LABS REQUIRED	DATE:	RESULTS: ☐ WITHIN NORMAL LIMITS (WNL) ☐ ABNORMAL	

TUBERCULOSIS SCREENING QUESTIONNAIRE *(If YES, please provide additional testing)*

1. Productive Cough (Greater than 3 Weeks) ☐ NO ☐ YES		5. Fever/Chills ☐ NO ☐ YES	
2. Chest Pains ☐ NO ☐ YES		6. Fatigue/Tiredness for more than 3 Weeks ☐ NO ☐ YES	
3. Blood-Streaked Sputum ☐ NO ☐ YES		7. Night Sweats for unknown reason ☐ NO ☐ YES	
4. Unexplained Weight Loss ☐ NO ☐ YES		8. PersistentShortness of Breath ☐ NO ☐ YES	

BASELINE INDIVIDUAL TB RISK ASSESSMENT *(If YES, please provide additional testing)*

Temporary or permanent residence of >1 month in a country with a high TB rate	☐ NO ☐ YES
Current or planned immunosuppression	☐ NO ☐ YES
Close contact with someone who has had infections TB disease since the last TB test	☐ NO ☐ YES
Have you been treated with medication for TB?	☐ NO ☐ YES
Have you had a prior diagnosis of active TB/Latent TB infection or a positive skin test or positive blood test for TB?	☐ NO ☐ YES

INFLUENZA VACCINE

☐PROVIDED ☐DECLINED (Must Sign Declination)	**DATE:**	**LOT#:**

☐ This individual is free from any health impairment (free of communicable diseases and free of habituation) that Is a potential risk to the patient or other employee or which may Interfere with the performance of his/her duties including the habituation or addiction to drugs or alcohol. Based on the Health History provided, Physical Exam, and/or Lap test performed, to this person's physical and emotional condition, he/she will be permitted to work in the health care field.

☐ This individual is able to work with the following limitations: _____

☐ This individual is not physically/mentally able to work (specify reason): _____

PHYSICIAN SIGNATURE_____ **DATE:**_____

PHYSICIAN STAMP_____ **LICENSE #:**_____

Declination of Influenza Vaccination
For Health Care Personnel

Employee's Name:_____ Employee's ID#:_____

I have been advised that I should receive the influenza vaccine to protect myself and the patients I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider. I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare personnel to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this healthcare facility, coworkers, my family and my community.

- **Because I have refused vaccination against influenza, I will be required to wear surgical or procedure masks in areas where patients or residents may be present during the influenza season.**

I acknowledge that I have read this document in its entirety and fully understand it. Despite these facts, I have decided to decline the influenza vaccine by my signature below. I realize that I may re-address this issue at any time and accept vaccination in the future.

Signature:_____ Date:_____

Witness: _____ Date:_____