MAIN: 40-04 JUNCTION BLVD. CORONA, NY 11368 • PHONE: 718-713-0005 • FAX: 718-713-0008 • WWW.MARKSHHC.COM

CDPAP SELF ANNUAL HEALTH ASSESSMENT

NAME:	DATE OF BIRTH:	SSN (Last 4):
ADDRESS:	PHONE:	

HAVE YOU HAD ANY OF THE FOLLOWING CONDITIONS BELOW SINCE YOUR LAST ASSESSMENT?

	NO	YES		NO	YES
Migraine Headaches?			Frequent Colds Or Other Respiratory Problems?		
Change in Energy Level?			Chest Pain/Pressure In Chest		
Swelling in Legs/Feet?			Unintentionally Lost or Gained Weight?		
Back Pain?			Pain When Urinating Or Blood In Urine?		
High Blood Pressure?			Persistent Lumps Or Sores?		
Fainting or Dizziness			Surgery In The Past Year?		
Change In Bowel Habits?			Illnesses Or Injuries In the Past Year?		
Loss Of Appetite?			Medications that could Interfere with your Job? IF YES, List Below:		

MEDICATION LIST

MEDICATION NAME	STRENGTH	FREQUENCY	ROUTE (EX: MOUTH)	CONDITION MEDICATION TAKEN FOR

TUBERCULOSIS SCREENING QUESTIONAIRE

	NO	YES		NO	YES
Chest Pains			Night Sweats For No Known Reason		
Blood-Streaked Sputum			Persistent Shortness of Breath		
Unexplained Weight Loss			Chronic Cough (greater than 3 weeks)		
Fever/Chills			Fatigue/Tiredness for more than 3 weeks		

BASELINE INDIVIDUAL TB RISK ASSESSMENT	NO	YES
History of temporary or permanent residence (for>1 month) in a country with a high TB rate		
Do you have any medical condition, or are taking any medications, which suppress your immune system?		
Have you been in contact with anyone with active tuberculosis disease in the past year?		

<u>Are you free</u> from the habituation or addiction to alcohol, depressants, stimulants, narcotics, or other drugs or substances with may alter your behavior?

YES □ Initials: _____ NO □ Initials: _____

<u>Are you free</u> from any health impairments which are of potential risk to a patient or which might interfere with the performance of your duties and free of communicable diseases?

YES □ Initials: _____ NO □ Initials: _____

I have read the above and declare that I have no injury, illness, or ailment other than as specifically identified that may interfere with the performance of my job responsibilities. I certify that I am not habituated or addicted to any depressants, stimulants, narcotics, drugs, alcohol or other substances that may alter my behavior.

EMPLOYEE SIGNATURE: _____ DATE: _____

FOR OFFICE USE ONLY

I the undersigned, have reviewed this self health assessment with full knowledge that the above individual was found to be:

□ ***<u>Fit for Duty</u>***

□ ***<u>Not Fit for Duty</u>*** - Individual was advised of the need of a physical evaluation with physician to be completed by _____

RN SIGNATURE: _____ DATE: _____

This self health assesment is not valid if you develop new symptoms. Moreover, new signs or symptoms should prompt urgent evaluation with your physician and immediate notification to Marks Home Care Agency.

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:_____