

# New Associate Health Assessments

Associate Health Services provides health assessments and a post-offer physical exam for all new Scotland Health Care System associates. Please review the following information.

## How do I prepare for my visit:

1. Complete the attached highlighted forms **prior to** your appointment.
2. Obtain copies of all Immunization records. Childhood (baby book) and adulthood immunization record should be brought in for proof of immunity. These can usually be obtained from your family doctor, local health department or a previous employer. We will be looking specifically for last TB skin test, adult MMR vaccine and if you have had the Hepatitis B vaccine. By bringing these records, you will save time and effort in getting your blood drawn.
3. Bring all completed forms to the Associate Health Department on the day of your appointment. Please arrive 10-15 minutes prior to your scheduled time.
4. Excessive use of colognes or perfumes must be avoided. Guests, patients, **and other employees** can be very sensitive to perfumes. Please do **not** wear any products with **fragrance** on the day of **your appointment, to orientation, or to work.** Remember that scented products include **perfume, cologne, and scented lotions or hand creams.**

## What can I expect on the day of my visit:

All relevant health information will be assessed.

1. Rapid Drug screen collection will be performed on all applicants.
2. Titmus vision screen (eye exam) will be performed as part of all assessments.
3. The nurse will record measurements of height, weight, and vital signs.
4. Your **immunization records** will be reviewed for documentation of immunity to the following: measles, mumps, rubella, chickenpox and hepatitis B. If your records do not have the necessary documentation, blood will be drawn to make sure the employee is immune. **Bring your records with you.**
5. If you are a staff member that will be required to enter airborne isolation rooms, you will be required to complete the attached **"Respiratory Medical Questionnaire"**. A fit test will be conducted to determine brand, size and model of respirator you will need.
6. All employees, except those with a documented history of a past positive TB skin test, will have an **initial skin test** at the time of the new hire assessment. To comply with this policy the TB skin test will **only** be read in the **Associate Health Department** within 48-72 hours after placement.
  - After the reading of the initial TB skin test, the new hire will be instructed to return in one to three weeks for a **second step TB skin test**. Any positive reading at the time of hire will be referred to their local health department for further follow-up.
  - Those with a **past positive TB skin** test will get a baseline chest x-ray during the new hire assessment and complete the TB Screening Questionnaire.

Thank you in advance for your assistance. If you have questions about any attached forms or policies, please do not hesitate to contact the Associate Health Department at the number listed below.

Tammy Holloway, RN, BSN, COHN-S  
Assistant Director Associate Health  
910-291-7676

**Associate Health Assessment**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Dept: \_\_\_\_\_ Exam Date: \_\_\_\_\_ Time In: \_\_\_\_\_

Reason for Exam:  Pre-placement  Annual  Other

Social Security No: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Home Phone: ( ) \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Cell Phone: ( ) \_\_\_\_\_

City/State: \_\_\_\_\_ Zip: \_\_\_\_\_ Family Doctor: \_\_\_\_\_

**MEDICAL HEALTH HISTORY: Have you ever had any of the following? Check YES or NO on each**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Epilepsy/Seizures/Fits/Convulsions | <input type="checkbox"/> Yes <input type="checkbox"/> No Peptic Ulcer                 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Allergies               | <input type="checkbox"/> Yes <input type="checkbox"/> No Extensive Confinement from illness | <input type="checkbox"/> Yes <input type="checkbox"/> No Pneumonia                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No AIDS                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Fainting/Dizzy Spells              | <input type="checkbox"/> Yes <input type="checkbox"/> No Poliomyelitis                |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Amputations             | <input type="checkbox"/> Yes <input type="checkbox"/> No Foot Problems                      | <input type="checkbox"/> Yes <input type="checkbox"/> No Psychological Problems       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Anemia                  | <input type="checkbox"/> Yes <input type="checkbox"/> No Headaches (Frequent)               | <input type="checkbox"/> Yes <input type="checkbox"/> No Pulmonary Disease            |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Ankylosis of Joint      | <input type="checkbox"/> Yes <input type="checkbox"/> No Head Injury                        | <input type="checkbox"/> Yes <input type="checkbox"/> No Rheumatic Fever              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Arteriosclerosis        | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Attack                       | <input type="checkbox"/> Yes <input type="checkbox"/> No Ruptured Intervertebral Disc |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Back Problems/Injuries  | <input type="checkbox"/> Yes <input type="checkbox"/> No Heart Disease                      | <input type="checkbox"/> Yes <input type="checkbox"/> No Scars                        |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bone/Joint Problems     | <input type="checkbox"/> Yes <input type="checkbox"/> No Heavy Metal Poisoning              | <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of Breath          |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Brain Damage            | <input type="checkbox"/> Yes <input type="checkbox"/> No Hemophilia                         | <input type="checkbox"/> Yes <input type="checkbox"/> No Sickle Cell Anemia           |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Breathing/Lung Problems | <input type="checkbox"/> Yes <input type="checkbox"/> No Hepatitis                          | <input type="checkbox"/> Yes <input type="checkbox"/> No Silicosis                    |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bronchitis              | <input type="checkbox"/> Yes <input type="checkbox"/> No Hernia                             | <input type="checkbox"/> Yes <input type="checkbox"/> No Sinus Problems               |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Bursitis                | <input type="checkbox"/> Yes <input type="checkbox"/> No High Blood Pressure                | <input type="checkbox"/> Yes <input type="checkbox"/> No Skin Rash or Infections      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer/Tumor            | <input type="checkbox"/> Yes <input type="checkbox"/> No Hodgkins Disease                   | <input type="checkbox"/> Yes <input type="checkbox"/> No Sore Throat (Frequent)       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Carpel Tunnel Syndrome  | <input type="checkbox"/> Yes <input type="checkbox"/> No Hyperinsulinism                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Spinal Disc Disease          |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Cerebral Palsy          | <input type="checkbox"/> Yes <input type="checkbox"/> No Ionizing Radiation Injury          | <input type="checkbox"/> Yes <input type="checkbox"/> No Stomach Problems             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain              | <input type="checkbox"/> Yes <input type="checkbox"/> No Jaundice                           | <input type="checkbox"/> Yes <input type="checkbox"/> No Stroke                       |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chronic Cough           | <input type="checkbox"/> Yes <input type="checkbox"/> No Kidney Problems                    | <input type="checkbox"/> Yes <input type="checkbox"/> No Swelling of Legs/Ankles      |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Compressed Air Sequelae | <input type="checkbox"/> Yes <input type="checkbox"/> No Loss of Sight                      | <input type="checkbox"/> Yes <input type="checkbox"/> No Thrombophlebitis             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Colds (frequent)        | <input type="checkbox"/> Yes <input type="checkbox"/> No Mental Retardation                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Tuberculosis                 |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Deafness                | <input type="checkbox"/> Yes <input type="checkbox"/> No Motor Vehicle Crash                | <input type="checkbox"/> Yes <input type="checkbox"/> No Varicose Veins               |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes                | <input type="checkbox"/> Yes <input type="checkbox"/> No Multiple Sclerosis                 | <input type="checkbox"/> Yes <input type="checkbox"/> No Venereal Disease             |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Ear Problems            | <input type="checkbox"/> Yes <input type="checkbox"/> No Osteomyelitis                      | <input type="checkbox"/> Yes <input type="checkbox"/> No Vision Problems              |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Emphysema               | <input type="checkbox"/> Yes <input type="checkbox"/> No Parkinson's Disease                |   |

**Please list any allergies:**

- Medication Allergies: \_\_\_\_\_
- Food Allergies: \_\_\_\_\_
- Latex, powder, vinyl, nitrile, or dye allergies: \_\_\_\_\_
- Other allergies: \_\_\_\_\_

**LIST ALL CURRENT MEDICATIONS:**

NAME:	DOSE:	HOW OFTEN:	PHYSICIAN PRESCRIBED
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**HEALTH HISTORY:** Answer **Yes** or **No** to the following:

1. Have you ever had a **positive** TB skin test?  YES  NO if yes, when & what medication taken and for how long: \_\_\_\_\_
2. Do you smoke?  YES  NO Have you ever smoked?  YES  NO If yes, what age did you quit \_\_\_\_\_ Total # of years smoked \_\_\_\_\_
3. Do you drink alcohol?  YES  NO If yes, how much and how often do you drink? \_\_\_\_\_
4. Based on your job description, do you currently have any physical or mental limitations and/or restrictions that would keep you from performing the essential functions of your new position? (**Examples would be: limited lifting, bending, climbing, pushing, pulling, squatting, sitting, standing, walking, etc.**)  YES  NO If yes, please describe or list the limitations: \_\_\_\_\_
5. Are you receiving any medical treatment at the present time?  YES  NO if yes, give reason \_\_\_\_\_
6. Do you wear a brace or use an appliance?  YES  NO
7. Have you had any recent exposures to infectious diseases?  YES  NO
8. Were you exposed to hazards during previous work assignments? This could include chemicals/cleaning compounds Radiations, dust or other respiratory hazards, excessive sun, infectious disease or bloodborne pathogen potential etc. If yes, please describe \_\_\_\_\_  YES  NO
9. Do you currently use or have you used additive/habit forming drugs or medications that make you drowsy?  YES  NO
10. Have you ever had a blood clot?  YES  NO  
If **yes**, where? \_\_\_\_\_ when? \_\_\_\_\_
11. Do you **currently** have an infection? \_\_\_\_\_  YES  NO
12. Do you currently have an uncontrolled metabolic disease (diabetes, thyrotoxicosis, gout, myxedema, etc.) or serious disorder (mononucleosis, hepatitis, etc.)? Comments \_\_\_\_\_  YES  NO
13. Has your doctor ever told you that you have a bone, joint, or musculoskeletal problem, such as arthritis or sciatica, that has been made worse by exercise or are you **currently** under medical care for any bone, joint or musculoskeletal problem?  YES  NO
14. Are you pregnant?  YES  NO
15. Do you require any accommodation or special consideration for any condition?  YES  NO
16. Do you have any condition (illness, infection, or medication), which affects your immune system, making you more Susceptible to infection?  YES  NO

**PLEASE LIST ANY OPERATIONS/FRACTURES/SERIOUS ILLNESS OR INJURIES YOU HAVE HAD:**

YEAR	PROBLEM:	PHYSICIAN	TYPE OF SURGERY:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**WORKER'S COMPENSATION HISTORY:** *Have you ever had?*

Have you ever been Injured on the job?	Date of Injury/Illness	Type of Injury/Illness	Workers Comp Benefits received?	Do you have any permanent restrictions?	Did you receive an impairment rating?
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

The Genetic Information Non-Discrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

I understand and acknowledge that Scotland Health Care System on the truth of the information that I have provided herein as a basis for my continued employment and that falsification of any of the information I have provided shall be grounds for my immediate dismissal. To that end, I certify that the information I have given herein is true and complete and I give permission for this medical examination. I also have been given an opportunity to ask any questions I might have about the information requested. I authorize release of medical information to this facility which may be necessary in determining my ability to meet the requirements of the job for which I am applying.

\_\_\_\_\_  
Signature of Applicant

\_\_\_\_\_  
Date

**PHYSICAL EXAMINATION: TO BE COMPLETED BY MEDICAL STAFF/CHAPERONE**

Temp: \_\_\_\_\_ B/P: \_\_\_\_\_ / \_\_\_\_\_ Pulse: \_\_\_\_\_ Resp: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ LMP: \_\_\_\_\_

		Yes	No
Skin	Skin color, mucosa pink	<input type="checkbox"/>	<input type="checkbox"/>
	Temperature warm	<input type="checkbox"/>	<input type="checkbox"/>
	Tugor normal	<input type="checkbox"/>	<input type="checkbox"/>
	Macules, papules, lesions, rash	<input type="checkbox"/>	<input type="checkbox"/>
Nails	Nail plate smooth and even	<input type="checkbox"/>	<input type="checkbox"/>
	Beds pink	<input type="checkbox"/>	<input type="checkbox"/>
	Capillary refill < 3 seconds	<input type="checkbox"/>	<input type="checkbox"/>
	Clubbing	<input type="checkbox"/>	<input type="checkbox"/>
Head	Shape symmetrical	<input type="checkbox"/>	<input type="checkbox"/>
Eyes	PERRLA	<input type="checkbox"/>	<input type="checkbox"/>
	Far (R) _____ / _____ (L) _____ / _____ (B) _____ / _____ Color Pass	<input type="checkbox"/>	<input type="checkbox"/>
Ears	Tympanic membrane (shiny, translucent, pearl-gray color)	<input type="checkbox"/>	<input type="checkbox"/>
Nose	Septum aligned	<input type="checkbox"/>	<input type="checkbox"/>
	Mucosa pink	<input type="checkbox"/>	<input type="checkbox"/>
Neck	Veins nondistended	<input type="checkbox"/>	<input type="checkbox"/>
	ROM full	<input type="checkbox"/>	<input type="checkbox"/>
	Swallowing intact	<input type="checkbox"/>	<input type="checkbox"/>
	Cervical lymph nodes palpable, small, nontender	<input type="checkbox"/>	<input type="checkbox"/>
	Thyroid size normal	<input type="checkbox"/>	<input type="checkbox"/>
Lungs	Chest expansion symmetrical	<input type="checkbox"/>	<input type="checkbox"/>
	Respirations regular	<input type="checkbox"/>	<input type="checkbox"/>
	Breath sounds clear	<input type="checkbox"/>	<input type="checkbox"/>
	Cough (nonproductive, productive) (circle)	<input type="checkbox"/>	<input type="checkbox"/>
Heart	Rhythm regular	<input type="checkbox"/>	<input type="checkbox"/>
	Regular rate	<input type="checkbox"/>	<input type="checkbox"/>
	Murmur	<input type="checkbox"/>	<input type="checkbox"/>
Upper Extremity	Shoulder ROM full bilateral	<input type="checkbox"/>	<input type="checkbox"/>
	Elbow ROM full bilateral	<input type="checkbox"/>	<input type="checkbox"/>
	Wrist ROM full bilateral	<input type="checkbox"/>	<input type="checkbox"/>
	Radial pulses present	<input type="checkbox"/>	<input type="checkbox"/>
	Phalen's (right, left)	<input type="checkbox"/>	<input type="checkbox"/>
	Tinel's sign (right, left)	<input type="checkbox"/>	<input type="checkbox"/>
Back/Lower Extremity	Gait steady	<input type="checkbox"/>	<input type="checkbox"/>
	Full ROM (hip, knee, ankle)	<input type="checkbox"/>	<input type="checkbox"/>
	Leg raise	<input type="checkbox"/>	<input type="checkbox"/>
	Toe touch (inches from ground _____)	<input type="checkbox"/>	<input type="checkbox"/>
Abdomen	Bowel sounds present	<input type="checkbox"/>	<input type="checkbox"/>
	Rebound tenderness	<input type="checkbox"/>	<input type="checkbox"/>
	Masses	<input type="checkbox"/>	<input type="checkbox"/>

Referral to OH MD:  YES  NO

Comments: \_\_\_\_\_

In my opinion this employee is:

- Able to perform the essential functions of the job.
- Able to perform the essential functions of the job with the following restrictions/limitations: \_\_\_\_\_
- Performing this job would pose a direct threat to this employee or others in the work place. As per section 630.2(r) under the Americans with Disabilities Act, only assessments that directly impact the performance of essential job functions were considered in my opinion.

Signature of Examiner: \_\_\_\_\_ Date: \_\_\_\_\_ Time Out: \_\_\_\_\_

Signature of Medical Provider \_\_\_\_\_ Date: \_\_\_\_\_

Patients with Abnormal Findings: I have been notified of my evaluation results indicating the above findings. I have been advised by the Occupational Medical Provider to follow-up with my family physician. Patient signature: \_\_\_\_\_ Date: \_\_\_\_\_

## PATIENT SUMMARY LIST/MEDICATION RECONCILIATION FORM

Name: \_\_\_\_\_ DOB \_\_\_\_\_ MR # \_\_\_\_\_ Date \_\_\_\_\_

Allergies (if applicable-place allergy sticker with allergies listed on the outside of chart)  NKDA

DRUG	REACTION

### PRESENT MEDICATIONS (include OTC and Herbal medications)

DATE	NAME	DOSE	FREQ	Continue/ Discontinued	PCP	Pt. States No Provider	Summary Mailed, Faxed or Interoffice Mail	Date & Time	Initials
				Continue Discontinued					
				Continue Discontinued					
				Continue Discontinued					
				Continue Discontinued					
				Continue Discontinued					
				Continue Discontinued					
				Continue Discontinued					
				Continue Discontinued					
				Continue Discontinued					
				Continue Discontinued					

### INJURIES

DATE	PROBLEM	PHYSICIAN	W/C	Yes	Closed	Open	No

### SIGNIFICANT SURGICAL HISTORY

DATE	PROBLEM	PHYSICIAN	

### SIGNIFICANT MEDICAL HISTORY

- HTN  
  Cancer  
  Depression  
  DM  
  Stroke  
  Hypercholesterol  
  Cardiac/MI  
 Ulcers  
  Anemia

**SOCIAL HISTORY:** Current Tobacco  No  Yes  Ever Smoke # Pks/Day \_\_\_\_\_ # Yrs Smoked \_\_\_\_\_  
 Alcohol  No  Yes How Much? \_\_\_\_\_ Other Drug Use?  No  Yes If yes, what? \_\_\_\_\_  
 Literate  No  Yes Level of Education:  Elementary  High School  College  Other \_\_\_\_\_  
 Second Job  No  Yes If yes, what? \_\_\_\_\_  
 Hobbies: \_\_\_\_\_  
 Other: \_\_\_\_\_

Reviewed /Reconciled By/Date:

/ /	/ /
/ /	/ /
/ /	/ /

# Tetanus/Diphtheria/Pertussis (Td/Tdap) Vaccine Administration Record

Employee Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ ID# / SS# \_\_\_\_\_  
 Employer: \_\_\_\_\_ Department: \_\_\_\_\_ Job Title: \_\_\_\_\_

## Vaccine:

Tetanus, diphtheria, and Pertussis are all caused by bacteria. Diphtheria and Pertussis are spread from person to person. Tetanus enters the body through cuts, scratches, or wounds. Immunization is one of the best ways to prevent disease from tetanus (lockjaw), diphtheria, and Pertussis (whooping cough)

## Contraindications: You should not take this vaccine without checking with your doctor if:

- You are sick right now with anything more serious than a cold;
- You have had a serious life-threatening reaction to Tetanus (DTP/DtaP/Td/Tdap) shots before;
- Persons who have had Guillain Barre Syndrome;
- You are taking a drug or undergoing a treatment that lowers the body's resistance to infection, such as: Cortisone, prednisone, certain anticancer drugs, or irradiation.
- You have had a serious life-threatening reaction to any component of the vaccine. Vaccine components can be found by going to [www.cdc.gov/nip/publications/pink/appendices/b/excipient-table-2.pdf](http://www.cdc.gov/nip/publications/pink/appendices/b/excipient-table-2.pdf).
- Adacel (Sanofi Pasteur) is licensed only for persons ages 11-64 years.
- Have epilepsy or other nervous system problems.

**Note:** Use of Td or Tdap is not contraindicated in pregnancy. At the provider's discretion, either vaccine may be administered during the 2<sup>nd</sup> or 3<sup>rd</sup> trimester. Anyone who has a moderate or severe illness should wait until they recover before getting Td/Tdap.

## Possible Adverse Events:

Many people have no reaction. Among patients that noticed any of these symptoms, most stated that they did not cause interference with normal activities: You may have none or some of these possible adverse events:

- Redness; swelling; or pain at or around the injection site,
- Mild fever of at least 100.4°F;
- Headache
- Tiredness
- Nausea, vomiting, diarrhea, stomach ache has occurred in 1 in 10 adults;
- Other mild problems reported include chills, body aches, sore joints, rash and swollen lymph glands

- Are you sick, in any way today?  Yes  No
- Are you pregnant or have you missed a period?  Yes  No
- Do you have an acute respiratory infection or other active infection?  Yes  No
- Have you ever been told you are allergic to Formalin preparations?  Yes  No  Don't Know
- Are you allergic to any medicine, eggs, or any vaccine or vaccine Component?  Yes  No
- Have you received any radiation therapy?  Yes  No
- Are you presently taking corticosteroids?  Yes  No
- Do you, any person who lives with you, or any person you take care of have cancer, leukemia, AIDS, or any other immune system problem?  Yes  No

## Consent or Declination

I have read the vaccine information statement on Td/Tdap vaccine provided by Scotland Healthcare System. I have had the opportunity to ask questions, which were answered to my satisfaction. I understand the benefits and risks of the Td/Tdap vaccine.

Yes, I want to take the Td/Tdap or Tetanus Toxoid Booster.

No, I do not wish to take the Td/Tdap or Tetanus Toxoid Booster.

Signature of person receiving or refusing vaccine \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_

### FOR CLINIC USE ONLY:

Circle ONE: **Tdap** **Td**

Temperature (less than 100°F) \_\_\_\_\_

Date Vaccine Administered: \_\_\_\_\_

Site of Injection:

Vaccine Manufacturer: \_\_\_\_\_

Lt. Deltoid  Rt. Deltoid  Other \_\_\_\_\_

Vaccine Lot Number: \_\_\_\_\_ Exp Date: \_\_\_\_\_

Signature of Vaccine Administrator: \_\_\_\_\_

Vaccine information statement given?  Yes  No

Title of Vaccine Administration:  RN  LPN  Other \_\_\_\_\_

VIS Dated Td & Tdap (2/24/15)

\_\_\_\_\_ No adverse reaction noted (Initial)

\_\_\_\_\_ Monitored for 15 minutes following administration (Initial)



# RECORD OF TUBERCULOSIS SCREENING

Name: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Department: \_\_\_\_\_ Title: \_\_\_\_\_

Date of Last Chest X-Ray: \_\_\_\_\_

Have you ever had:

1. Tuberculosis?  Yes  No If yes, when and where were you treated? \_\_\_\_\_

2. TB Skin Test?  Yes  No  Don't Know If yes, was it positive?  Yes  No If positive, how long ago, and where did you receive this test? \_\_\_\_\_

3. Been inoculated with BCG?  Yes  No If yes, how long ago and where did you receive this inoculation? \_\_\_\_\_

## TB Risk Questionnaire: Please answer the following questions: Check Yes or No

1. Were you born outside the USA in one of the following parts of the World: Africa, Asia, Central America, South America, or Eastern Europe? If yes, explain \_\_\_\_\_  Yes  No
2. Have you traveled outside the USA and lived for more than one month in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe? If yes, explain \_\_\_\_\_  Yes  No
3. Do you have a compromised immune system such as from any of the following conditions: HIV/AIDS, organ or bone marrow transplantation, diabetes, immunosuppressive medicines (e.g. prednisone, Remicade), leukemia, lymphomas, cancer of the head or neck, gastrectomy or jejeunal bypass, end-stage renal disease (on dialysis), or silicosis? If yes, explain \_\_\_\_\_  Yes  No
4. Have you ever done one of the following: used crack cocaine, injected illegal drugs, worked or resided in jail or prison, worked or resided at a homeless shelter?  Yes  No
5. Have you worked as a healthcare worker in direct contact with patients?  Yes  No

## TB Symptom Questionnaire

Please answer the following questions. Do you currently have any of the following symptoms?

1. Unexplained cough lasting more than 3 weeks?  Yes  No
2. Unexplained weight loss?  Yes  No
3. Unexplained appetite loss?  Yes  No
4. Unexplained fever?  Yes  No
5. Night sweats  Yes  No
6. Shortness of breath?  Yes  No
7. Chest pain?  Yes  No
8. Unexplained fatigue?  Yes  No

The above health statement is accurate to the best of my knowledge. I will notify Employee Health and see my MD and/or local Health Department if my health status changes.

Signature \_\_\_\_\_

Date \_\_\_\_\_

Witness \_\_\_\_\_

Date \_\_\_\_\_

Skin Test:

Standard Mantoux Test  Other  
Test Site:  Left forearm  Right forearm  Other  
Dosage:  0.1 ml of Tubersol injected intradermal

Mfg.: \_\_\_\_\_  
Lot #: \_\_\_\_\_  
Exp. Date: \_\_\_\_\_

Date Given: \_\_\_\_\_ Time given: \_\_\_\_\_

Signature: \_\_\_\_\_

Test Results: (Read 48-72 hours after injection)

Date results read \_\_\_/\_\_\_/\_\_\_ By: \_\_\_\_\_

TB Skin Test Results were:  Negative  Positive, size of induration \_\_\_ mm.

# Drug Testing Procedure Fact Sheet For Non DOT

NOTICE TO ALL DRUG SCREEN DONORS

New Drug Screen Law Effective December 1, 2002

**IT IS NOW A CRIMINAL OFFENSE TO ATTEMPT TO ALTER OR DEFRAUD DRUG OR ALCOHOL SCREENING TESTS.**

The General Assembly of North Carolina enacts: Section 1. Article 52 of Chapter 14 of the General Statutes is amended by adding a new section to read S 14-401.20. Defrauding drug and alcohol screening tests; penalty.

- 1) It is unlawful for a person to do any of the following
  - a) Sell, give away, distribute, or market urine in this State or transport urine into this State with the intent that it be used to defraud a drug or alcohol screening test.
  - b) Attempt to foil or defeat a drug or alcohol screening test by the substitution or spiking of a sample or the advertisement of a sample substitution or other spiking device or measure.
- 2) It is unlawful for a person to do any of the following:
  - a) Adulterate urine or other bodily fluid sample with the intent to defraud a drug or alcohol screening test.
  - b) Possess adulterants that are intended to be used to adulterate a urine or other bodily fluid sample for the purpose of defrauding a drug or alcohol screening test.
  - c) Sell adulterants with the intent that they be used to adulterate a urine or other bodily fluid sample for the purpose of defrauding a drug or alcohol screening test.
- 3) A violation of this section is punishable as follows:
  - a) For first offense under this section, the person is guilty of a Class 1 misdemeanor.
  - b) For a second or subsequent offense under this section, the person is guilty of a Class 1 felony.

**If caught, offenders can be prosecuted by their company!**

## Non-Federal Drug Testing Custody and Control Form (For Non DOT only).

You have been selected for a urine drug test. The testing procedure to be followed is in accordance with the Scotland Memorial Hospital Occupational Health and Laboratory procedure manuals. It is designed to provide accuracy while protecting your rights to privacy. Failure to cooperate will deem you unqualified, and the test will not be performed. This fact sheet was developed to advise you of your responsibilities, your rights, and to help you understand the procedure.

1. You must register before beginning the drug screening process.
2. **A picture I.D. is required.**
3. Once you have been registered you must remain in the waiting room until your drug screen is completed.
4. Any friends, family, or the company representative, etc. must remain in the waiting room while you are being tested.
5. You will be asked to hang any loose outer garments/possessions on the coat rack in the specimen collection area.
6. You must **WASH (USE SOAP), RINSE and DRY** your hands before you collect the specimen.
7. A sealed specimen collection kit will be provided to you.
8. You will proceed to the bathroom and provide a 45cc urine specimen (approximately ½ cup) in a container. If you have a problem providing an adequate sample you need to drink fluids to induce urination. Only a 3 hours length of time will be allowed for the collection of the specimen. The Occupational Health Department will notify the industry requesting the test of any failure to provide an acceptable specimen.
9. Give the specimen container to the collector, making certain that it is kept within our view at all times, until it is officially sealed and labeled. Do not attempt to tamper with or substitute the specimen. It will be visually inspected. A temperature will be measured. If the staff suspects tampering or temperature out of range, your company will be notified and we will follow the company protocol.
10. Sign, initial and date where indicated (on the chain of custody form and container label).
11. Observe the sealing and labeling of specimen.
12. Be sure to keep up with any paperwork you are to return to the employer.
13. All results of drug screen applicants are reported directly to the designated company official that you are testing for. Scotland Memorial Hospital cannot release the results to anyone else.
14. **YOU ARE TO DISPLAY APPROPRIATE BEHAVIOR DURING THE COLLECTION PROCESS. ANY ABUSIVE REMARKS OR ACTIONS WILL CANCEL THE SCREENING PROCESS AND THE COMPANY WILL BE NOTIFIED.**

When you have finished reading this, sign and date this form to acknowledge your understanding of the drug test. Please have your photo I.D. ready and any chain of custody forms (drug testing form) provided by the company for which you are being tested. Take all of these documents to the registration desk with this fact sheet.

Signature: \_\_\_\_\_



**NC CONTROLLED SUBSTANCE EXAMINATION REGULATION ACT**  
**INITIAL NOTICE TO EMPLOYEES/APPLICANTS**

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In accordance with our company policy, you have been selected for a New Hire Controlled substance test (specify: Random, Post Incident, New Hire, Reasonable Suspicion). In accordance with 13 NCAC 20.0401, this notice explains your rights and responsibilities under the NC Controlled Substance Examination Regulation Act (CSERA) (Chapter 95, Article 20 of the NC of the NC General Statutes) and the corresponding administrative rules (Title 13, Chapter 20 of the NC Administrative Code).

- You may refuse this test, however, your job or employment opportunity may be in jeopardy.
- Although applicants may be screened by means of a Quick Test, any positive result must be confirmed by an approved lab using gas chromatography with mass spectrometry (GM/MS), or equivalent accepted method before hiring decisions are made.
- Current employees cannot be screened by means of a Quick Test.
- An approved laboratory must perform testing samples.
- You can request a re-test of any positive sample. Re-test must be of the same sample and must be paid for by the employee.
- You can file a complaint with the NC Department of Labor-Wages and Hour Bureau at (919) 807-2796 or 1-800-2798 or 1-800-NC-LABOR if you believe procedural requirements of the CSR were violated. The Department has no jurisdiction regarding an employer's requirement for controlled substance testing or its decision regarding results of controlled substance testing.

Please sign:

\_\_\_\_\_  
Employee/Applicant

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employer Representative

\_\_\_\_\_  
Date

# LATEX ALLERGY QUESTIONNAIRE

Please answer the following: Risk Factor Assessment:

## Exposure History:

- A. Are you a health care worker?  Yes  No  
If you answer No, what is your occupation? \_\_\_\_\_
- B. Do you wear latex gloves regularly or are you otherwise exposed to latex regularly?  Yes  No
- C. Do you have a history of eczema or other rashes on your hands?  Yes  No
- D. Do you have a medical history of frequent surgeries or invasive medical procedures?  Yes  No  
If yes, how many? \_\_\_\_\_  
Did these take place when you were an infant?  Yes  No
- E. Do you have a history of "hay fever" or other common allergie?  Yes  No
- F. Do your fellow workers wear latex gloves regularly?  Yes  No
- G. Do you take beta-blocker medication (high blood pressure or migraine headaches, e.g.: Inderal)?  Yes  No

- H. **Circle** any food below that cause hives, itching of the lips or throat, or more severe symptoms when you eat or handle them:

avocado, apple, pear, celery, carrot, hazelnut, kiwi, papaya, pineapple, peach, cherry, plum, apricot, banana, melon, chestnut, nectarine, grape, fig, passion fruit, tomatoes or potatoes

## Contact Dermatitis Assessment: (for patients who wear latex gloves frequently)

- A. Do you have rash, itching, cracking, chapping, scaling or weeping of the skin from latex glove use?  Yes  No
- B. Have these symptoms recently changed or worsened?  Yes  No
- C. Have you used a different brand of latex gloves?  
If so, have your symptoms persisted?  Yes  No
- D. Have you used non-latex gloves?  Yes  No
- E. If so, have you had the same or similar symptoms as non-latex gloves?  Yes  No
- F. Do these symptoms persist when you stop wearing all gloves?  Yes  No

## Contact Urticaria (Hives) Assessment: (for patients who wear latex gloves frequently)

- A. When you wear or are around others wearing latex gloves do you get hives, red itchy swollen hands within 30 minutes, "water blisters" on your hands within a day?  Yes  No

## Aerosol Reaction Assessment:

- A. When you wear or are around others wearing latex gloves, have you noted:
- Itchy, red eyes, fits of sneezing, runny or stuffy nose, itching of the nose or palate?  Yes  No
  - Shortness of breath, wheezing, chest tightness or difficulty breathing?  Yes  No
  - Other acute reactions, including generalized or severe swelling or shock?  Yes  No

## History of Reactions Suggestive of Latex Allergy:

- A. Do you have a history of shock or allergic reaction(s) during medical, surgical, or dental procedures or operations?  Yes  No
- B. Have you had itching, swelling or other symptoms following dental, rectal, or pelvic exams?  Yes  No
- C. Have you experienced swelling or difficulty breathing after blowing up a balloon?  Yes  No
- D. Do rubber handles, rubber bands or elastic bands on clothing cause any discomfort?  Yes  No
- E. Other symptoms that might be related or caused by latex Exposure?  Yes  No

FOR OFFICE USE ONLY:

Form reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

Place in Latex Allergy Sensitivity:  YES  NO Note: \_\_\_\_\_

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## Hepatitis B Vaccine Acceptance/Declination Form

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Employee Name: \_\_\_\_\_

Date of Hire: \_\_\_\_\_

**I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B Virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine at no charge to me.**

I have decided to:

\_\_\_\_\_ Request that I receive the Hepatitis B Vaccine

\_\_\_\_\_ Decline vaccination due to:

\_\_\_\_\_ Titer evidences immunity

\_\_\_\_\_ Previous Hepatitis B vaccination

\_\_\_\_\_ Decline for other personal reasons

\_\_\_\_\_ Medical contraindication (contraindications include: pregnancy, active infection such as a cold or bronchitis, lactation, allergy to yeast or yeast products.)

***Declination:***

I understand that:

- due to my occupational exposure to blood or other potential infectious materials I may be at increased risk of acquiring hepatitis B virus (HBV) infection;
- I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to myself. However, I still wish to decline the Hepatitis B vaccination at this time;
- declining this vaccine, I continue to be at increased risk of acquiring Hepatitis B, a serious disease;
- If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

\_\_\_\_\_  
Employee Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Social Security Number

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Date

Employment termination date: \_\_\_\_\_

Note: This record must be maintained throughout employment and for 30 years thereafter.

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## Documentation of Immunity to Chicken Pox

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I, as the above documented employee, do hereby certify that the statement below is accurate to the best of my knowledge.

\_\_\_\_\_ I HAVE had chickenpox or history of shingles.

\_\_\_\_\_ I do NOT have a history of chickenpox or history of shingles.

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Safe Lifting Competency – Back Injury Prevention:

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Please Print:

Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_

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### Safe Lifting Competency (Basic Lift):

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Employee has demonstrated competency and good lifting technique in the following areas:

- Positions body close to the object.
- Stands with a wide stance; either one foot forward or feet shoulder width apart.
- Keeps back straight and uses legs and hips to lower self to the object.
- Moves the load close to the body before attempting to lift.
- Grasps the object firmly with both hands.
- Tests the load prior to lifting to assess the need for assistance.
- Bends Knees, extends the legs, keeps the back straight and lifts the load by holding object close to the body.

Employee has Physical Limitations/Restrictions that would prevent them from demonstrating a safe lifting technique. However, employee is able to verbalize competency of proper lifting techniques.

The signatures below indicate that the Employee successfully demonstrated or verbalized (**verbalizes only if employee has physical limitations**) Safe Lifting Technique and any questions the Employee might have had during this sessions were answered.

Note: \_\_\_\_\_

Evaluator Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Associate Signature: \_\_\_\_\_ Date: \_\_\_\_\_