

HEALTH SCREENING

Name: _____ Spouse or Next of Kin: _____
 Address: _____ Phone #: _____
 Date of Birth _____ Physician: _____ Clinic: _____

Medical History (Check those you have or have had)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Heart Trouble | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Backaches & Strain | <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Tuberculosis or |
| <input type="checkbox"/> Bleeding (excessive) | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Paralysis | Positive TB Test |

Have you had the disease OR received immunizations for the following:

Check the box (X) if you had the disease OR Fill in the date of last immunization (xx/xx/xx) for the disease.

Disease or Immunization for the following:	Had Disease	Date of last immunization unless otherwise noted
Measles, Mumps, Rubella (MMR vaccine – 2 doses required)		
Hepatitis B (HBV vaccine – 3 step vaccine series)		
Chicken Pox (Varicella vaccine – 2 doses required)		
Diphtheria or Tetanus (DPT, DTaP, DT – childhood series) *T indicates the tetanus vaccine *D is the pediatric diphtheria vaccine *P indicates the pertussis vaccine		
Td booster required <i>every 10 years</i> after initial childhood series * d indicates the adult diphtheria vaccine		
Tdap (a <i>one-time dose is required</i> of health care providers under age 65) • The Tdap can be used as the Td booster		
Polio (OPV or IPV vaccine) *P indicates the polio vaccine		
Influenza (Annual vaccination of TIV or LAIV)		
Negative TB test	X	Last TB screening test: (Mantoux test): _____
OR		
Positive TB screening test:	+ TB test; When?	You are required to provide verification of medical follow up.
OR		
Had Tuberculosis disease	If had TB; When?	You are required to provide verification of medical follow up.

Do you have any present health problems? _____ If yes, describe: _____

Have you had any serious injuries or illness? _____

Do you have any communicable diseases? _____ If yes, describe: _____

Signature _____ Date _____