Jackson HEALTH SYSTEM

PUBLIC HEALTH TRUST

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EMPLOYEE HEALTH SERVICES

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Pre-employment Health Screen

Instructions and Forms

Employee Health Services
PH: 786-466-8381
Fax: 305-355-1503
I ŜI·fűK2ŦŦMŎŜ@jhsmiami.org
Hour of Operations
Monday – Friday: 7:30am – 4:00pm
Excluding Holidays

Jackson Medical Towers
1500 N.W. 12th Ave
11th Floor, Suite 1103
Miami, FL 33136

Human Resources
Employee Health Services
Jackson Medical Tower
1500 N.W. 12th Avenue
Miami, FL 33136

Welcome to Jackson Health System!

Please read the "Pre-employment Health Screening Instructions" carefully. All forms must be completed, signed. Bring completed forms with you the day of exam. Failure to follow the instructions as outlined in the documents may result in having to resubmit document(s) and consequently delay your start date.

PRE-EMPLOYMENT HEALTH SCREENING INSTRUCTIONS

All JHS employees must complete a physical exam, have received immunizations, and be tested for drugs of abuse at least 15 days prior to the first day of employment. Applicants who do not complete the pre-employment health screening requirements; who are confirmed positive for illegal drugs or unauthorized use of controlled substances; and/or who refuse any drug test, will not be allowed to work for Jackson Health System.

1. **Complete required EHS Health Forms with required signatures and proof of immunization records or titers**
   - *a)* Registration and Consent Form (your signature is required*)*
   - *b)* EHS Pre-Employment Health Screen (Primary Care Physician or Health Care Facility signature required **ONLY** if physical exam completed outside of Jackson Health System)
   - *c)* EHS Medical History Statement Form (your signature required)
   - *d)* Drug Usage Analysis Form (your signature required)
   - *e)* Vaccine Declination and Consent Forms (your signature required)
   - *f)* Respirator Medical Evaluation Questionnaire Form
   - *g)* Respirator Clearance Form
   - *h)* Immunization records and/ or titers
2. Bring government issued photo identification (Driver's License, Passport, and State ID).
3. Plan to arrive at least 30 minutes early to allow for any delays.
4. Late arrival 30 minutes or more to appointment time is subject to rescheduling.
5. Plan to spend at least two (2) hours. Parking is free for the first two hours.
6. To comply with JHS Safety guidelines and limited space, we asked that you leave children at home.

Should you have any questions or concerns, please call 786-466-8381 or email healthoffice@jhsmiami.org

We look forward to seeing you!

Thank you,

Employee Health Services (EHS) Human Resources

Employee Health Services

Pre-employment Health Screening Instructions

Phone: 786-466-8381 **Fax: 305-355-1503 Email**: Healthoffice@jhsmiami.org

Please read the **"Pre-employment Health Screening Instructions"** carefully. All forms must be completed and signed. Bring completed forms with you the day of exam. Failure to follow the instructions as outlined in the documents may result in having to resubmit document(s) and consequently delay your start date.

To ensure compliance and to expedite completion of physical and drug testing requirements, please do the following:

REQUIREMENT: Complete EHS Health Forms (A thru E) with required signatures in New Hire Packet

a) Registration and Consent Form (your signature is required)
b) EHS Pre-Employment Health Screen (Primary Care Physician or Health Care Facility signature required **ONLY** if physical exam completed outside of Jackson Health System)
c) EHS Medical History Statement Form (your signature required)
d) Drug Usage Analysis Form (your signature is required)
e) Vaccine Declination and Consent Forms (your signature required)

Health Screen Requirements

The following are mandatory for pre-employment health screen for Health Care Workers:

1) **EHS History Medical Statement** including prior injuries, exposures, substance abuse history and any current work restrictions.
2) **Tuberculosis Skin Testing (TST): "Verbal History" of Positive TB skin test is not accepted.**
   Record of the last two (2) negative TST.
   a) Proof of 1 TB Skin Test or QuantiFeron (QFT) within 12 months of your start date; and 2nd TST or QFT within the last 3 months of your start date.
   b) If you don't have proof of TB skin test in the last 12 months, you will need two (2) skin tests one week apart.
3) **Chest x-ray:** Proof of chest x-ray taken within the past 6 months if you have a history of a positive (+) TB skin test.
4) **MMR:** Proof of two (2) Measles, Mumps and Rubella vaccine (MMR) OR Proof of positive titers.
5) **Varicella (Chickenpox):** Proof of two (2) Varivax vaccine or Proof of positive (+) Varicella titer.
6) **Tetanus, Diphtheria and Pertussis (Tdap)**: Proof dated within last 10 years or sign declination form
7) **Flu Vaccine:** Administered within the last six months
8) **Hepatitis B Vaccine: Proof of all three (3) OR** Hepatitis B Surface Antigen Titer (HBsAB) or sign a declination form.
9) **Respirator Fit Test:** for all new hires or proof within the past 12 months first visit to EHS.
10) **Vision Screen:** first visit at EHS or proof within the past 6 months.

Drug Test Preparation Instructions

- **Bring Photo ID**
- You can have a regular breakfast **but do not consume over 8oz. of fluids** within 2 hours prior to appointment
- **Bring medication bottles or prescription description from a pharmacy** for **any controlled substances** taken in the two weeks prior to the drug test date, such as sleeping pills, narcotic pain pills, or pills for anxiety or depression. Please follow link https://www.dea.gov/druginfo/factsheets.shtml to view illegal drug substances

Tuberculosis Skin Testing (TST)

- Be prepared to return in 48 hours to have the TB skin test read.

Failed Drug Test Includes ANY of the Following Without Exception:

- **Positive test for an illegal substance**
- **Positive test for a controlled substance** without a valid prescription
- **No Show** for a Drug Test Appointment

A certified Medical Review Officer (MRO) reviews all drug tests.

Respirator Fit Testing Preparation

Proof within the past 12 months or first visit to EHS.

- No eating, drinking, or chewing gum 15 minutes prior to testing.

Employee Health Services
Registration and Consent

Instructions: **please print legibly and complete all blanks. If the questions are not applicable, please indicate (N/A).**

Name (as appears on your Social Security card)**:**		**Social Security #**
Phone Number:		**Email**:
Date of Birth:		**Race:** ☐W ☐B ☐H ☐Other
Address:		**Apt #:**
City:	**State**:	**Zip Code**:
Gender: ☐Female ☐Male ☐ Unknown ☐Other	**Preferred Gender:** ☐Female ☐Male ☐ Unknown ☐Other	**Marital Status**: ☐Single ☐Married ☐Divorced ☐ Domestic Partner
Other Last Names Used:		
Have you ever been a patient, employee, or student at Jackson Health System before? ☐**Yes** ☐**No**		
If yes, under what name(s) were you admitted? _____ Year(s)_____		

Acknowledgement of Pre-Employment Drug Testing and Health Requirements

My signature below means that I understand that all JHS employees must participate in a **physical exam, complete all immunizations,** and be tested for **alcohol and illegal drugs and use of a controlled substance prior to the first day of employment**. I understand that if I do not complete the health screening requirements as requested by Employee Health Services, I will be subject to disciplinary action. I understand that my urine will be tested for narcotics, depressants, hallucinogens, stimulants, marijuana, or other controlled substances according to the Drug Free Workplace Act and the Miami- Dade County Scientific and Administrative Protocol. If I am confirmed positive for an illegal drug **or** if my urine is **positive for an illegal substance or positive** for a **controlled substance** without a valid medical prescription**, I** will not be allowed to work for Jackson Health System and will be separated from employment, Graduate Medical Education Program or any other Jackson Health System program for which I am required to have pre-employment health screening.

I also understand that **licensed professionals who have a confirmed positive drug test will be reported to the Florida Agency for Health Care Administration Licensing Board and/or to the Intervention Project For Nurses or Professional Resource Network** if eligible to participate, and that all expenses for further medical evaluations as a result of a positive drug test or appeal will be my responsibility. I have read Employee Health Services Instructions for Pre-Employment Health Screening and understand and agree to complete the health screening, immunizations, blood tests required, and deadlines for submitting required forms and for scheduling urine drug screen appointments, and instructions for preparing for the drug test, respirator fit test and any other examinations required before or after arrival at Jackson Health System.

Authorization for Release of Information (Under 18 Requires Legal Guardian)

I agree to allow Jackson Health Systems Employee Health Services to contact my Health Care Provider and obtain information from my medical records for the purposes of determining my fitness to work and to verify immunizations, lab tests, x-rays and other required communicable disease information required by Jackson Health System. I consent to use a copy of this authorization as an original.

Signature: _____ Date: _____

Employee Health Services Pre-Employment Health Screen

Phone: 786-466-8381 Email: e-Clearance@jhsmiami.org Fax: 305-355-1503

Pre-Employment Health Screen Form: Must be completed by your **Primary Care Physician/ Health Care Provider**

To Be Completed by Applicant for Employment or House Staff Placement			
Name(Last, First, MI)PRINT:			Social Security#:
Birth Place:	Birth Date	Program Specialty	Contact Preference: ☐ Email ☐ Mobile ☐ Phone
Phone #	Mobile #	Email	Date to Start at JHS

Health Care Provider Health Screening Verification

Please verify that this applicant has completed the health screening requirements listed below. Falsification of health information will result in termination from employment or school. Records are subject to random audits. **Illegible** forms will not be accepted.

Tuberculosis Screening (Mandatory)

Tuberculosis Skin Testing (TST): Record of the last two negative TST. Proof of 1 TB Skin test or Quantiferon (QFT) within 12 months of your start date and the 2 TST or QFT within the last 3 months of your start date. If you have no proof of TB Skin Test or QFT in the last 12 months, you will need two (2) skin test one week apart.

TST # 1 Date_____ Location R or L Result in MM _____ Date_____

TST # 2 Date _____ Location R or L Result in MM _____ Date_____

Positive Tuberculosis TB Skin Tests Date _____ **TB symptoms** ☐ No ☐ Yes

Interferon-Gamma Release Assay (IGRA) Quantiferon or T-SPOT ☐ Date _____ **Result:** ☐ Positive ☐ Negative

Proof of Chest X-ray taken within the past six months if you have a history of a positive (+) PPD.

Date _____ **Result:** ☐ Normal ☐ Abnormal

Received INH or other TB treatment?: ☐ NA ☐ No ☐ Yes Date: _____ Number of Months _____

Communicable Disease Immunizations and Immunity Screening

MMR (Mandatory): Proof of two (2) Measles, Mumps and Rubella Vaccine OR proof of positive (+) MMR titers.

☐ **MMR #1 Date** _____ ☐ **MMR #2 Date** _____ If no proof give ☐ **MMR Booster** ☐ **Date:** _____ **OR**

Measles(Rubeola)Titer: Date _____ **Result:** ☐ Positive ☐ Negative ☐ Equivocal

Mumps Titer: Date _____ **Result:** ☐ Positive ☐ Negative ☐ Equivocal

Rubella Titer: Date _____ **Result:** ☐ Positive ☐ Negative ☐ Equivocal

Varicella (Chickenpox): (Mandatory): Proof of two (2) Varivax vaccine OR proof of positive (+) Varicella titer.

Date _____ **Result:** ☐ Positive ☐ Negative ☐ Equivocal

Varicella Vaccine: Date #1 _____ **Date #2** _____

Tetanus/Diphtheria/ Pertussis (Tdap) Proof dated within last 10 years **OR** sign declination form

Date_____ **or** ☐**Tdap Vaccine Date:** _____

Flu Vaccine: Last Date Administered: _____

Hepatitis B Vaccine Proof all three (3) Hepatitis B Vaccine OR sign a declination form

☐ Declined vaccine /Date: _____

Series 1 Dates: #1_____, #2_____, #3_____, HBsAbTiter: Date _____ ☐ Positive ☐ Negative

***Series 2* Dates:** #1_____, #2_____, #3_____, HBsAbTiter: Date _____ ☐ Negative ☐ Positive

If negative after 2nd series Hepatitis B Surface Antigen Titer: Date _____ ☐ Negative ☐ Positive ☐ Non-Responder

Fitness for Duty / Free of Communicable Disease Statement

*** MUST BE COMPLETED BY YOUR HEALTHCARE PROVIDER***

This applicant has been examined by me and found to be free of communicable disease and fit to work in the occupation listed on this form. I certify that the above information is correct and proof is on medical file.

Print legible Name of Healthcare Provider: _____

(Mandatory)Provider Medical License No: _____

Signature_____ **Date**_____

Name of Medical Facility Completing This Form		**MD or Facility Stamp**
Address (Street, City, State, Zip)		
Phone	**Fax or Email**	

OTHER REQUIRED SCREENING

If testing has not been completed you will be tested when you arrive at JHS Employee Health Services

Vision Screening (Mandatory)

First visit at EHS or proof within the past six(6) months of start date

To be completed by Primary Care Physician, Optometrist or Health Care Provider

Visual Acuity (Mandatory): Date _____ ☐ **Pass** ☐ **Fail** Right _____/_____ Left _____ /_____

Corrected: ☐ Contact Lenses ☐ Eye Glasses ☐ NA **Color (Mandatory): Date**_____ ☐ **Normal** ☐ **Abnormal**

If color tests are abnormal, describe. _____

Can vision be corrected? ☐ No ☐ Yes If Yes Explain: _____

Completed by: _____**Company** _____**Phone:**_____

Respirator Fit Testing (RFT) (Mandatory)

First visit at EHS or proof within the past 12 months of start date

(To be completed by a Health Care Provider)

Indicate Result: ☐ **Pass** ☐ **Fail** Respirator Class: ☐ **N95**

Respirator Model: ☐3M 1860 Small ☐3M 1860 Regular ☐N95 1870 ☐**Other:** _____ **Last Date:** _____

Completed by: _____ **Phone:** _____

Employee Health Services
Medical History Statement

Name:_____ **DOB**: _____ **Age**:_____

Department:_____ **Job Title**:_____ **SS#**_____

A. HAVE YOU EVER BEEN DIAGNOSED AND TREATED FOR THE FOLLOWING?

*If you answer **"Yes"** to any of the diagnosis with "*" below, please complete Appendix **A***

Yes	No		Yes	No	
___	___	High cholesterol/triglyceride	___	___	Thyroid disease
___	___	Heart attack	___	___	Ulcer/Stomach problems
___	___	*High blood pressure >150/90	___	___	Anemia
___	___	Diabetes	___	___	Arthritis
___	___	Cancer/tumors	___	___	*Back injury/pain
___	___	Asthma/wheezing	___	___	Varicose veins
___	___	*Epilepsy	___	___	Kidney disease
___	___	Skin problems	___	___	Hernia
___	___	Rheumatic fever	___	___	Hay fever/allergies
___	___	Serious injury/auto accident	___	___	Painful periods
___	___	*Communicable Diseases			
___	___	Other_____			

B. HAVE YOU RECEIVED MEDICAL CARE FOR OR HAD ANY OF THE FOLLOWING SYMPTOMS IN THE PAST 5 YEARS? *If you answer **"Yes"** to any of the symptoms with "*" below, please complete Appendix **A***

Yes	No		Yes	No	
___	___	*Fainting/dizziness	___	___	Chronic fever
___	___	Severe headaches	___	___	Blood in urine
___	___	*Convulsions or fits	___	___	Painful urination
___	___	*Loss of memory	___	___	Frequent urination
___	___	Deafness	___	___	Jaundice
___	___	Hearing loss	___	___	Vomiting blood
___	___	Nosebleeds	___	___	Recent weight loss
___	___	Frequent hoarseness	___	___	Coughing up blood
___	___	Shortness of breath	___	___	Frequent chronic cough
___	___	*Chest pain	___	___	Frequent vomiting
___	___	*Palpitations	___	___	Night sweats
___	___	Swollen ankles	___	___	Black/bloody Stools
___	___	Painful joints	___	___	Frequent diarrhea
___	___	*Psychiatric disorders, i.e. anxiety, depression, attention deficit disorder, PTSD, etc.	___	___	Constipation

C. ALLERGIES

Yes	No	
___	___	Environmental (Dust, Pollen)
___	___	Food
___	___	Drugs
___	___	Latex gloves
___	___	Other:_____

D. SUBSTANCE USE

Yes	No	
___	___	Tobacco/packs per day: _____
___	___	Alcohol intake drinks per Wk _____
___	___	Caffeine /cups per day: _____
___	___	Other: _____

Employee Health Services
Medical History Statement

Name: _____

E. MEDICATION HISTORY

Please list ALL over-the-counter drugs (cough medicines, antihistamines, diet pills, anti-diarrheals) and prescription medications, including injections you have taken or received in the **LAST TWO WEEKS**.

OVER THE COUNTER DRUGS

Brand Name	Reason for Taking	Daily Dosage	Date Last Taken
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

PRESCRIPTION MEDICATIONS

Medication Name	Prescribing Doctor & Phone	Reason for Taking	Daily Dosage	Date & Time Last Taken

F. OPERATIONS/HOSPITALIZATIONS

List reasons and dates:

_____

_____

LAST CHEXT X-RAY DATE _____ RESULTS:_____

G. **LAST EKG DATE** _____ RESULTS:_____

H. FEMALES ONLY

Last menstrual period: _____

Last pap smear: _____

Last breast exam: _____

# of pregnancies: _____ # Live births: _____

I. MEN ONLY

History of prostate problems: _____

Swelling or pain in scrotum: _____

Employee Health Services
Medical History Statement

Name: _____

J. WORK HISTORY

	Yes	No
Have you ever worn a respirator ?	___	___
Have you ever been unable to hold a job or perform certain tasks in a job because of?	___	___
a. Inability to perform certain motions	___	___
b. Inability to assume certain positions	___	___
c. Sensitivity to any chemicals, dust, latex, gloves, etc.	___	___
d. Other medical and/or mental reasons	___	___

Have you ever been?	Yes	No
a. Refused employment because of health	___	___
b. Refused insurance because of health	___	___
c. A patient in mental hospital or a drug rehab program?	___	___
d. Used a self-help rehabilitation program for drug/alcohol abuse	___	___
e. Required to participate in a drugs of abuse program e.g. IPN, PRN?	___	___
f. Rejected or discharged from military service because		
g. of physical/mental reasons	___	___

Have you ever applied for, received or intend to apply for workers' compensation or other injury compensation program? **Yes** **No**

If yes, describe _____

Do you have any physical or mental impairment that would prevent you from performing specific kinds of work? **Yes** **No**

Comments: _____

_____

_____

Certification / authorization

I hereby certify that all statements made on this form are true to the best of my knowledge. I fully realize that should an investigation disclose any misrepresentation, I will be subject to immediate dismissal.

_____ _____

SIGNATURE **DATE**

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Employee Health Services
Medical History Statement

APPENDIX A

MEDICAL INFORMATION STATEMENT/ PRE-EMPLOYMENT SCREENING

To be completed by Primary Care Provider (PCP) and/or Specialist according to medical condition when **"Yes"** is answer on any of the items with * on the Medical History Statement Form. Please indicate below, ability and stability to perform job duties.

Candidate Name:		**Date:**
Phone:	**DOB:**	**Social Security No.:**
Job Title:	**Department:**	
All information must be included. If does not apply, please write N/A on line. If you have any questions, please feel free to call us at (786) 466-8381. You may email e-Clearance@jhsmiami.org or fax to 305-355-1503. Thank you.		
Candidate Authorization: *I authorize you to release information about my health condition to the Employee Health Services. I am willing for a copy of this release to be used as an original.* **Client**: _____ **Witness:** _____		

Diagnosis (listed as **"Yes"** on Medical History Statement)_____

Type of surgery/Date(s):_____

Dates evaluated or treated for this condition: _____

Follow-up appointment(s) planned and frequency _____

List Medications: _____

Will medications affect work performance? ☐ No ☐ Yes (If yes, please indicate the expected side effects)

_____

_____

Is person under your care for this condition? ☐ No ☐ Yes (Explain below)

_____

_____

Does this person have restrictions that may affect ability to work? ☐ No ☐ Yes

Please list restrictions: ☐N/A

_____

_____

Is this person stable, safe and able to work full duties? ☐ No ☐ Yes

Additional Comments: _____

_____

Print M.D. Name: _____ **SIGNATURE:** _____

(Mandatory) M.D. License No: _____ **Phone Number:** _____

OFFICE STAMP REQUIRED

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Employee Health Services

DRUG USAGE ANALYSIS

Name: _____ **Social Security:** _____

Contact Number: _____ **Job Title:** _____

CONSENT

I understand and agree to be tested for use of narcotics, depressants, hallucinogens, stimulants, marijuana, alcoholic beverages or other controlled substances as identified by Miami Dade County or its agents. I understand that this information will be released only to representatives of the Public Health Trust and Miami Dade County. In the case of reasonable suspicion or mandatory physical exam, I understand that this information will be released to my supervisor, the Employee Assistance Program and Human Resources. If I am licensed by the State of Florida, I understand this information will also be reported to the Agency for Health Care Administration and/or The Impaired Nurse Program or Physician Resource Network. It has been explained to me that if the specimen is found adulterated in any way, I will have to return for retesting and further evaluation within 24-48 hours of being notified by Employee Health Services Health Services (EHS). I understand that any evidence of tampering with the specimen or failure to follow EHS direction may be considered an attempt to avoid drug testing and may result in my being disqualified for a job or disciplinary action if I am an employee.

Applicant/Employee Signature: _____ **Date:** _____

MEDICATION/DRUG HISTORY

Please list ALL over-the-counter drugs (cough medicines, antihistamines, diet pills, anti-diarrheals) and prescription medications, including injections you have taken or received in the **LAST TWO WEEKS**.

OVER THE COUNTER DRUGS

Brand Name	Reason for Taking	Daily Dosage	Date Last Taken

PRESCRIPTION MEDICATIONS

Medication Name	Prescribing Doctor & Phone	Reason for Taking	Daily Dosage	Date & Time Last Taken

I certify that the above information is correct

Signature: _____ **Date:** _____

Respirator Medical Evaluation Questionnaire

Section 1. **(Mandatory)** The following information must be provided by every employee who has been selected to use any type of respirator **(please print)**

1. **Name:** _____ **Job Title:** _____ **Today's Date:** _____
2. **Age** (to nearest year): _____ **Height**: _____ft. _____in. **Weight:** _____lbs.
3. **Gender:** ☐Male ☐Female ☐Unknown ☐Other **Preferred Gender:** ☐Male ☐Female ☐Unknown ☐Other
4. A phone number where you can be reached by health care professional: _____ The best time to phone at this number: _____
5. Has your employer told you how to contact the health care professional who will review this questionnaire? ☐Yes ☐No
6. Check the type of face mask (respirator) you will use (you can check more than one category):
   a. _____ N, R, or P disposable respirator (filter-mask, non- cartridge type only).
   b. _____ Other type (for example, half- or full-face piece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
7. Have you worn a (respirator)? ☐Yes (Include brand and model numbers) _____ ☐No

Section 2. **(Mandatory)** Questions 1 through 8 below must be answered (please check "yes" or "no").

	Yes	No
1. Do you currently smoke tobacco, or have you smoked tobacco in the last month?	☐	☐
2. Have you ***ever had*** any of the following conditions?		
a. Seizures (fits)	☐	☐
b. Diabetes (sugar disease)	☐	☐
c. Allergic reactions that interfere with your breathing	☐	☐
d. Claustrophobia (fear of closed-in places)	☐	☐
e. Trouble smelling odors	☐	☐
3. Have you ***ever had*** any of the following pulmonary or lung problems?		
a. Asbestosis	☐	☐
b. Asthma	☐	☐
c. Chronic bronchitis	☐	☐
d. Emphysema	☐	☐
e. Pneumonia	☐	☐
f. Tuberculosis	☐	☐
g. Silicosis	☐	☐
h. Pneumothorax (collapsed lung)	☐	☐
i. Lung cancer	☐	☐
j. Broken ribs	☐	☐
k. Any chest injury or surgeries	☐	☐
l. Any other lung problem that you've been told about?	☐	☐
4. Do you ***currently*** have any of the following symptoms of pulmonary or lung illness?		
a. Shortness of breath	☐	☐
b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline	☐	☐
c. Shortness of breath when walking with other people at an ordinary pace on level ground	☐	☐
d. Have to stop for breath when waling at your own pace on level ground	☐	☐
e. Shortness of breath when washing or dressing yourself	☐	☐
f. Shortness of breath that interferes with your job	☐	☐
g. Coughing that produces phlegm (thick sputum)	☐	☐
h. Coughing that wakes you early in the morning	☐	☐
i. Coughing that occurs mostly when you are lying down	☐	☐
j. Coughing up blood in the last month	☐	☐
k. Wheezing	☐	☐
l. Wheezing that interferes with your job	☐	☐
m. Chest pain when you breathe deeply	☐	☐
n. Any other symptoms that you think may be related to lung problems	☐	☐

	Yes	No
5. Have you ***ever had*** any of the following cardiovascular or heart problems?		
a. Heart attack	☐	☐
b. Stroke	☐	☐
c. Angina	☐	☐
d. Heart failure	☐	☐
e. Swelling in your legs or feet (not caused by walking)	☐	☐
f. Heart arrhythmia (heart beating irregularly)	☐	☐
g. High blood pressure	☐	☐
h. Any other heart problem that you've been told about?	☐	☐
6. Have you ***ever had*** any of the following cardiovascular or heart symptoms?		
a. Frequent pain or tightness in your chest	☐	☐
b. Pain or tightness in your chest during physical activity	☐	☐
c. Pain or tightness in your chest that interferes with your job	☐	☐
d. In the past two years, have you noticed your heart skipping or missing a beat	☐	☐
e. Heartburn or indigestion that is not related to eating	☐	☐
f. Any other symptoms that you think may be related to heart or circulation problems	☐	☐
7. Do you ***currently*** take medication for any of the following problems?		
a. Breathing or lung problems	☐	☐
b. Heart trouble	☐	☐
c. Blood pressure	☐	☐
d. Seizures (fits)	☐	☐
8. If you've used a face mask (respirator), have you ***ever had*** any of the following problems? (If you've never used a face mask (respirator), check the following space and go to question	☐	☐
a. Eye irritation	☐	☐
b. Skin allergies or rashes	☐	☐
c. Anxiety	☐	☐
d. General weakness or fatigue	☐	☐
e. Any other problem that interferes with your use of a face mask (respirator)? Describe_____	☐	☐

To be completed by Employee Health Services or Healthcare Provider

Approved to use face mask (respirator)? ☐Yes ☐No (If no give reason) _____

Provider Signature: _____ Date: _____

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Employee Health Services

Respirator Clearance Form

TO BE COMPLETED BY EMPLOYEE

Name:	**Badge #**	**DOB**	**Department**

Have you cared for a patient with Tuberculosis in the past 12 months? ☐ Yes ☐ No

Have you cared for or worked around patients on airborne or droplet isolation in the past 12 months? ☐ Yes ☐ No

Do you mix, administer, or work around patients receiving chemotherapy? ☐ Yes ☐ No

Have you worn a respirator before? ☐ Yes Model_____ Date: _____ Why? _____ ☐ No

Number of shifts you wear a respirator per week:	Length of time respirator is worn during a shift	When using respirator, work is:
☐Never ☐Less than 1 ☐1-4 ☐Almost every shift	☐Less than 1 hour ☐1-5 hours ☐ 5-12 hours	☐Light (sitting most of the time) ☐Moderate (Lifting/carrying 25 lbs. frequently, 50 lbs occasionally ☐Heavy(Lifting/carrying 50 lbs frequently, 100 lbs occasionally

Did you have trouble wearing the respirator? ☐ Yes ☐ No If yes, explain

Do you wear glasses or goggles with the respirator? ☐Yes ☐ No

Do you have facial hair such as a moustache, goatee, beard or long sideburns? ☐ Yes ☐ No

If you answered yes to any of the questions on the medical questionnaire, do you want to talk with the health care professional about the medical evaluation? ☐ Yes ☐ No

Did you eat, drink, chew gum or smoke 15 minutes prior to this test? ☐ Yes ☐ No

TO BE COMPLETED BY FIT TESTER

☐ **PASSED QUALITATIVE FIT TEST: Employee Can Only Use the Following Respirator**

☐ **FAILED QUALITATIVE FIT TEST: This Employee May Not Use the Following Respirators**

☐3M N-95 Model #1860R (Regular)
☐3M N95 Model #1860S (Small)
☐3M N95 Model #1870
☐Halyard N-95 Model #46727R (Regular)
☐Halyard N-95 Model #46827S (Small)
☐Other (List) _____

☐ **PASSED QUANTITATIVE FIT TEST: Employee Can Only Use the Following Respirator**

☐ **FAILED QUANTITATIVE FIT TEST: This Employee May Not Use the Following Respirators**

☐3M N95 Model #1860R (Regular)
☐3M N95 Model #1860S (Small)
☐3M N95 Model #1870
☐Halyard N-95 Model #46727R (Regular)
☐Halyard N-95 Model #46827S (Small)
☐Other (List) _____

☐ **REFERRAL TO EHS FOR FURTHER ACTION APPT. 786-466-8381** Date: Time:

☐Employee requires or requested a Respirator Medical Evaluation
☐Required to remove facial hair that interferes with fit. Return for fit testing on _____
☐Other (Explain)

No stated or obvious health contraindications to wearing a respirator. Final clearance is pending HCP Medical Clearance.

Fit Test Technician: **Date**:

I understand I am only approved to use the respirator model and size for which I have been fit tested. I have been given and understand instructions on how to put on, remove and handle the respirator safely. I also understand that if I loose or gain a significant amount of weight (≥ 20 lbs), have facial surgery, begin to use dentures or develop any new lung, cardiac or other major health problem, I should report to EHS for a new evaluation and fit test.

Employee Signature: **Date**:

To Be Completed By Employee Health Services or Health Care Provider

☐Medically Cleared for Respirator Use ☐Not Medically Cleared for Respirator Use

Reason: _____

HCP Signature: _____ **Date:** _____

Vaccine Declination or Consent

I have been given the CDC Vaccine Information Statement regarding the Hepatitis B Vaccine. I understand that I have a risk of acquiring Hepatitis B virus infection due to a job-related exposure to blood or other potentially infectious materials. I have been given the opportunity to be vaccinated with Hepatitis B Vaccine at no charge. I understand the risks and benefits of vaccination

☐ **I do not want to take the vaccine at this time**. I understand that by declining this vaccine, I continue to be at risk of Hepatitis B infection and should seek treatment for body fluid exposures. I understand that if I continue to be at risk of exposure, I can receive the vaccine at no charge at a later date.

☐ **I decline the vaccine because:** ☐ I have taken the vaccine ☐ I have a positive HbsAb ☐ I am a Hepatitis B carrier.

☐ **I consent to take the Hepatitis B Vaccine**. **I** understand that I am making a commitment to complete all three vaccines in the series. **The first one will be given now. I must return for the second vaccine in one month and the third vaccine five months after the second. I understand that I should return for a HbsAb titer in about three months from the last vaccine.** If the titer is negative, I will be given three additional shots in the same sequence. I understand that while I am receiving the vaccine, I may not be protected from Hepatitis B and may need treatment for body fluid exposures.

Signature: _____ **Date:** _____ **Provider:** _____ **Date:** _____

Use only for initial immunization series. Record any additional boosters on Treatment Sheet and Communicable Disease Record

Reason for Vaccine: ☐ New (Potential for Exposure to Body Fluids) ☐ Post Exposure Treatment ☐ Restart series

Previous vaccine: ☐No ☐Yes (dates/Location)_____ HbsAb: ☐No ☐Yes (Date/Results) _____

Previous exposures ☐No ☐Yes (dates/Location)_____ HbsAg: ☐No ☐Yes (Date/Results) _____

Pregnant: ☐No ☐Yes months_____ **Breast Feeding**? ☐No ☐Yes (OB/Pediatrician approval to start vaccine? ☐No ☐Yes)

Allergies to baker's yeast? ☐Yes ☐No History of anaphylactic or severe reaction due to allergies? ☐No ☐Yes Explain

(Definitions: HbsAb: Hepatitis B antibody HbsAg Hepatitis B antigen) Use comments for explanations

Candidate for vaccine?: ☐Yes ☐No(Explain)

Age_____ Height _____ Weight_____ Temperature_____ Smoker: ☐No ☐Yes Pack per day _____

History of Immunosuppression or immunosuppressive medication: ☐No ☐Yes Explain

Service	Date	Brand	Lot number	Dose/ & Route	Location Deltoid		Next Visit Date	Nurse
Vaccine 1				1cc IM	Right	Left		
Vaccine 2				1cc IM	Right	Left		
Vaccine 3				1cc IM	Right	Left		
HBsAb 1		**Action**: ☐ Positive , has immunity, stop Tracking						
Result Ab 1		☐ Negative: call back for Vaccine # 4 and HbsAg ☐ Results Reporting sent						
HBsAg		**Action**: ☐ Negative: continue vaccine. ☐Results Reporting sent						
Result Ag		☐ Positive: stop immunization, refer for medical evaluation.						
Vaccine 4				1cc IM	Right	Left		
Vaccine 5				1cc IM	Right	Left		
HBsAb 2.		**Action**: ☐ Positive, stop surveillance ☐Results Reporting Form sent						
Result Ab 2		☐ Negative: continue vaccine: Refer to Outreach for tracking.						
Referred to								
Vaccine 6				1cc IM	Right	Left		
HBsAb 3		☐ Positive, has immunity, stop tracking ☐Results Reporting sent						
Result		☐ Negative, call back for counseling regarding non-responder risk.						

Comments: (date and sign each note)

☐Stop surveillance. Employee is non-compliant with follow-up and must restart series.

☐Non-Responders**:** I have taken six or more vaccines and have not developed immunity to Hepatitis B. I understand that I continue to be at occupational risk of acquiring the disease. I understand standard precautions and other methods of minimizing my risk of becoming infected.

Health Care Provider (Print Name): _____ Signature:_____ Date_____

JACKSON HEALTH SYSTEMS EMPLOYEE HEALTH SERVICES		**Last Name**: _____
HO 002	**HEPATITIS B VACCINE FLOW SHEET**	**First Name**:_____ **SS#**:_____
Revised 8/17		

Jackson HEALTH SYSTEM
Miracles made daily.

Tetanus, Diphtheria and Pertussis Vaccine (Tdap)
Declination or Consent for Administration

Tetanus is an acute, often fatal disease caused by an extremely potent neurotoxin produced by Clostridium tetani. The toxin causes neuromuscular dysfunction, with rigidity and spasms of skeletal muscles. The muscle spasms usually involve the jaw (lockjaw) and neck, and then become generalized. Tetanus leads to death in up to 2 cases out of 10.

Diphtheria may cause both localized and generalized disease. It causes a thick covering in the back of the throat and can lead to breathing problems, paralysis, heart failure and even death.

Pertussis (*Whooping Cough*) is a disease of the respiratory tract, most often caused by Bordetella pertussis. It causes severe coughing spells, pneumonia, vomiting and disturbed sleep.

Tdap may be given during pregnancy (with a note of consent from OB-GYN).

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS

1. □ Yes □ No Have you received Tdap vaccine or Boostrix before?
2. □ Yes □ No Have you had a systemic allergic reaction, any adverse reaction, seizure, Guillain-Barre syndrome, coma or encephalopathy related to a previous tetanus and diphtheria toxoid and/or pertussis vaccine?
3. □ Yes □ No Do you currently have an acute illness or infection?
4. □ Yes □ No Do you currently have a progressive or unstable neurologic or uncontrolled seizure disorder?
5. □ Yes □ No Are you on anticoagulant therapy or do you have a bleeding disorder?
6. □ Yes □ No Do you have a severe allergy to latex?
7. □ Yes □ No Are you younger than 19 years of age?

Questions 9 and 10 for women only

8. □ Yes □ No Are or might you be pregnant? ***If yes, you MUST consult your obstetrician before receiving Tdap and provide a medical note*** stating you may receive.
9. □ Yes □ No If you are, or might be pregnant, have you discussed receiving Tdap with your obstetrician?

If you answered YES to questions 1 through 7 or NO to question 9, you should NOT receive Tdap today.

Possible Side Effects from vaccine:

1. Local reactions at site of injection, local redness and swelling with or without tenderness.
2. Hives (urticaria), itching, rash, headache, body aches and tiredness.
3. Transient fever may develop after the injection
4. Neurological complications reported very rarely include cochlear lesions, brachial plexus neuropathies, paralysis of radial and recurrent nerves, accommodation paresis or weakness, seizures and swallowing difficulty.

PLEASE CHECK ONE:

☐ **I have read the above information and have had an opportunity to ask questions regarding tetanus, diphtheria and pertussis vaccine. I have received the latest CDC Vaccine Information Sheet (VIS).**
I CONSENT TO Tdap VACCINE.

Patient: (Print Name) _____ **VIS Date** _____

Signature of parent, guardian, or adult volunteer: _____

Date of Vaccination _____ Site: 0.5 ml IM □ Right Deltoid □ Left Deltoid

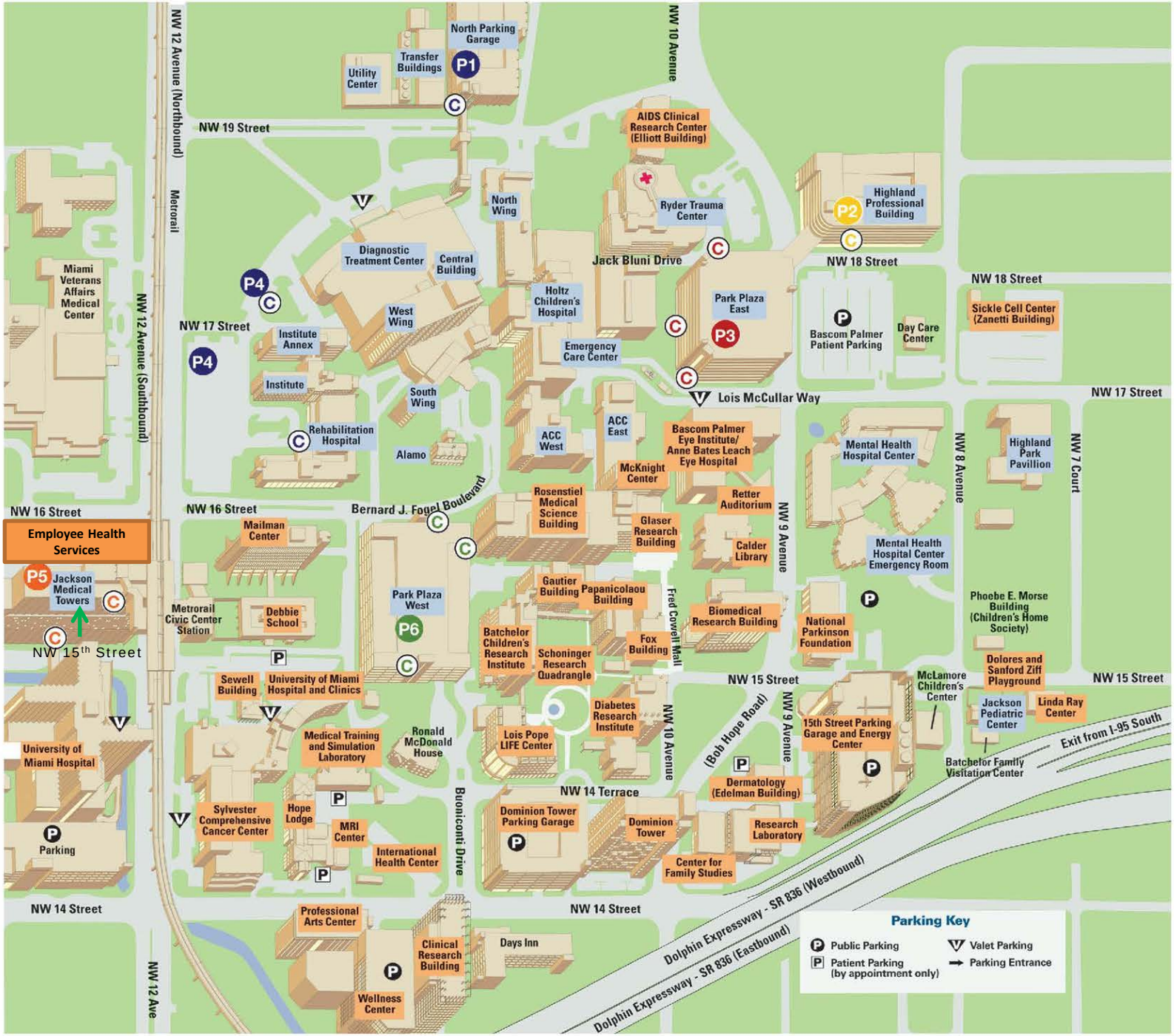
Manufacturer: _____ Lot #: _____ Expiration Date: _____

Administered by: (Signature) _____ (Print)_____

☐ **I acknowledge that I understand the risks and benefits of the Tdap vaccine, and have had the opportunity to ask questions. I DO NOT CONSENT TO Tdap VACCINE:**

Patient: (Print Name) _____ Date_____

Signature of parent guardian, or adult volunteer: _____



Jackson HEALTH SYSTEM

PUBLIC HEALTH TRUST

University of Miami / Jackson Memorial Medical Center Campus

- P1 BLUE GARAGE (North)
- P2 YELLOW GARAGE (Highland)
- P3 RED GARAGE (Park Plaza East)
- P4 BLUE LOT (Lot 5)
- P5 ORANGE GARAGE (Jackson Medical Towers)
- P6 GREEN GARAGE (Park Plaza West)

C C C C C

ChipCoin Automated Payment Station

P5

DESTINATION

Jackson Medical Towers
Employee Health Services
1500 NW 12th Ave
11th Floor, Suite 1103
Miami, FL 33136