T: (805) 385-5485
F: (805) 988-9607

Health Assessment/ TB Skin Test / Immunization Verification

Patient Name: **Last** **First** **Middle** **Birth Date** **Sex**

Address: **Street** **City** **County** **State** **Zip** **Phone: Home / Work**

Date of History: **Primary Care Provider** **Phone Number of Primary Care Provider**

	Y/N	COMMENTS		Y/N	COMMENTS
MEDICAL HISTORY			Sensitivity / Allergy to Latex		
Allergies Diabetes Respiratory		Type 1___ Type 2 ___	Learning Disabilities		
Problems (Levaquin or other antibiotic use?)			Developmental Disabilities		
Surgeries/Hospitalizations			HIV/STD		If HIV+, CD4 count Date
Cancer			Chronic Renal Failure		
Corticosteroids (Received equivalent of >15 mg/d Prednisone for >1 mo)			Liver Disease/Hepatitis (Risk factors HepB/C: IDU, HIV+, or birth in Asia, Africa, or Amazon basin)		
Organ Transplant			Autoimmune		
GI/Gastrectomy or jejunoileal bypass Weight at least			Arthritis/Gout		Use of Remicade, Humira or Enbrel?
10% less than ideal body weight			Neurological/Seizures		
Mental Illness/Disabilities			Vision/Hearing Disorder		
Skin Disease			Gyn/Pregnancy		
Hypertension/CVA		Blood Pressure_____/_____	Breast Feeding		
Heart Disease/PVD			Post-Partum		
Thyroid			Other		
Neurological/Seizures			Other		

MEDICATIONS TAKING, EXCLUDING TB DRUGS	START DATE	DOSAGE / SCHEDULE	STOP DATE	PRESCRIBING PHYSICIAN

SOCIAL HISTORY	Y/N	COMMENT
Tobacco use		_____ pks / day _____ years of use
Alcohol		Current # alcoholic drinks per week
HIV/AIDS Risk		
Drug Abuse		____ Non-injecting Drugs? ____ Injecting Drugs?

ADDITIONAL COMMENTS	COMMENTS

I hereby certify that the above facts are true to the best of my knowledge.	Signature:	Date:

Y= **If History Is Positive** N = **If History Is Negative**

(Continued on Reverse)

Last Name | First Name | Middle Name | Birthdate

Tuberculosis Health Assessment/History

SIGNS & SYMPTOMS OF TB	Y/N	DATE OF ONSET	COMMENTS
Cough (Persistent X3 Weeks)			
Weight Loss			
Fever / Chills			
Night Sweats			
Fatigue			
Loss of Appetite			

TUBERCULIN SKIN TEST

	Date Given:	Signature: Signature: Induration:	Site Forearm	R L
(48-72 Hours)	Date Read:	mm	License #:	
	Erythema: mm	Date:		
If TB skin test is positive or any induration, chest x-ray is required. Please attach a doctor's report with chest x-ray.			Results:	

IMMUNIZATION RECORDS — **Take proof of immunizations to your medical exam for verification.**

MMR(Measles, Mumps, Rubella Vaccination)**Date**	Date:		Signature:	
If MMR immunizations records are not available, the following titres are required:				
Rubella Titre Results:	Date:		Signature:	
Rubeola Titre Results:	Date:		Signature	
Hepatitis B Vaccine	Date 1St:	Date 2nd:	Date 3rd:	Signature:
Applicants are required to sign the Hepatitis B declination below, if they elect to not get the Hepatitis-B vaccine.				
Tetanus- Diphtheria	Date:		Signature:	
Varicella or titer				
Influenza Vaccine (October - May)	Date:		Signature:	

If previously vaccinated at another date or location, please provide proof of vaccine.

******FOR DECLINATION ONLY******

Hepatitis B Declination		**Influenza Vaccine Declination**	
I understand that due to my occupational and educational 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 hepatitis B vaccine; however, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future, I continue to have educational and 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.		I have declined to receive the influenza vaccine for the 20__ -20__ influenza season. I acknowledge that the influenza vaccine is recommended by the CDC for all healthcare workers to prevent infection and transmission of influenza and its complications, including death, to my patients, coworkers, family and community. **Indicate reason for declination:** ☐ **MASK NEEDED** o I don't like needles. o I believe I will get the flu if I get the shot. o My philosophical or religious beliefs prohibit vaccination. o I have a medical contraindication to receiving the vaccine. o Flu vaccine not available. o I do not wish to say why I decline.	
Applicant Signature:	Date:	Applicant Signature:	Date:

SIGNATURE

I certify that the person above, _____, has a normal physical and is able to participate in the program's physical activities, has no communicable diseases or any other health conditions that would create a hazard to themselves, any employees, visitors or patients at any time. They are able to perform the physical activities required for the program which they are applying for at Ventura Training Institute.

Medical Examiner: _____ **Date:**

Y= **If History Is Positive** N = **If History Is Negative**

Facility Stamp

(Orig. 9/2009; Rev. 8/2019)