Ventura Training Institute

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# 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**

| MEDICAL HISTORY | Y/N | COMMENTS | | Y/N | COMMENTS |
|---|---|---|---|---|---|
| Allergies | | | Sensitivity / Allergy to Latex | | |
| Diabetes | | Type 1___ Type 2 ___ | Learning Disabilities | | |
| Respiratory 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 | | | Arthritis/Gout | | Use of Remicade, Humira or Enbrel? |
| Weight at least 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: | Site Forearm R L |
| (48-72 Hours) | Date Read: | Signature: | License #: |
| | Erythema: mm | Induration: mm | |
| If TB skin test is positive or any induration, chest x-ray is required. Please attach a doctor's report with chest x-ray. | | Date: | 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**

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.

Applicant Signature: | Date:

**Influenza Vaccine Declination**

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**

- ○ I don't like needles.
- ○ I believe I will get the flu if I get the shot.
- ○ My philosophical or religious beliefs prohibit vaccination.
- ○ I have a medical contraindication to receiving the vaccine.
- ○ Flu vaccine not available.
- ○ I do not wish to say why I decline.

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)