PHYSICAL EXAMINATION FORM

RCN
REGIONAL CARE NETWORK

NAME	SOCIAL SECURITY #
ADDRESS	DATE OF BIRTH / /

PHYSICAL EXAM

HEIGHT	WEIGHT	HEART	LUNGS
B.P.	PULSE	BACK	ABDOMEN
EARS	NOSE	THROAT	EYES
MEDICAL HISTORY			

LAB TESTS

	DATE PLACED	DATE READ	RESULTS
1ST PPD / MANTOUX	/ /	/ /	mm
2ND PPD / MANTOUX	/ /	/ /	mm

	DATE	RESULTS	RESULTS
QUANTIFERON TB GOLD TEST	/ /		*ATTACH LAB REPORT
CHEST X-RAY	/ /		*ATTACH LAB REPORT
MUMPS	/ /		*ATTACH LAB REPORT
RUBELLA TITER	/ /	RATIO	*ATTACH LAB REPORT
RUBEOLA TITER (IF BORN IN 1957 OR LATER)	/ /	RATIO	*ATTACH LAB REPORT
DRUG SCREEN (MUST INCLUDE THC)	/ /		*ATTACH LAB REPORT

	DATE ADMINISTERED	MANUFACTURER	LOT NUMBER	EXPIRATION DATE
INFLUENZA (FLU) VACCINE	/ /			/ /

IMMUNIZATIONS (FOR NON-IMMUNE OR EQUIVOCAL)

	DATE		1ST DATE	2ND DATE
RUBELLA	/ /	RUBEOLA	/ /	/ /

☐ THE ABOVE NAMED INDIVIDUAL HAS A **PAST HISTORY OF POSITIVE TUBERCULOSIS TEST** AND A **NEGATIVE CHEST X-RAY**, AND IS PRESENTLY DEMONSTRATING **NO SIGNS OR SYMPTOMS OF ACTIVE TUBERCULOSIS** AND MAY WORK WITHOUT LIMITATIONS

DECLARATION

BASED ON HEALTH HISTORY, PHYSICAL EXAMS AND/OR LABORATORY TESTS PERFORMED, THIS PATIENT'S CONDITION WILL PERMIT HIM/HER TO WORK IN THE HEALTH CARE FIELD. IN ADDITION, BASED UPON THIS EXAMINATION, THIS INDIVIDUAL IS FREE FROM ANY HEALTH IMPAIRMENT WHICH IS OF POTENTIAL RISK TO THE PATIENT OR WHICH MIGHT INTERFERE WITH THE PERFORMANCE OF HIS/HER DUTIES, INCLUDING THE HABITUATION OR ADDICTION TO DEPRESSANTS, STIMULANTS, NARCOTICS, ALCOHOL OR ANY OTHER DRUG SUBSTANCES.

PLEASE CHECK: ☐FULLY EMPLOYABLE ☐EMPLOYABLE WITH LIMITATIONS ☐NOT CURRENTLY EMPLOYABLE

PHYSICIAN INFORMATION

NAME	LICENSE	DATE / /
PHYSICIAN SIGNATURE		
FACILITY STAMP		

HEPATITIS B VACCINATION FORM

RCN
REGIONAL CARE NETWORK

DATE _____

EMPLOYEE NAME _____

EMPLOYEE ID # _____

WILL ACCEPT VACCINE ☐ **YES** ☐ **NO**

I understand that due to my occupational exposure to blood or other potential infectious materials I may be at risk for acquiring Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to have occupational exposure to blood or other potentially infectious materials. Should I want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at no charge.

EMPLOYEE SIGNATURE _____ **DATE** _____

FACILITY REPRESENTATIVE SIGNATURE _____ **DATE** _____

Please only sign if Declining Flu shot

Declination of Influenza Vaccination
For Health Care Personnel

Employee's Name:_____ Employee's ID#:_____

I have been advised that I should receive the influenza vaccine to protect myself and the patients I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider. I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare personnel to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this healthcare facility, coworkers, my family and my community.

- **Because I have refused vaccination against influenza, I will be required to wear surgical or procedure masks in areas where patients or residents may be present during the influenza season.**

I acknowledge that I have read this document in its entirety and fully understand it. Despite these facts, I have decided to decline the influenza vaccine by my signature below. I realize that I may re-address this issue at any time and accept vaccination in the future.

Signature:_____ Date:_____