COOPER KIDS THERAPY ASSOCIATES
2 Roosevelt Avenue, Syosset, NY 11791

MEDICAL FORM

NAME: _____ PHONE #: _____

ADDRESS: _____

PHYSICAL EXAM:

HEIGHT _____ WEIGHT _____
B.P. _____ PULSE _____ RESP. _____
HEART _____ CHEST _____

HABITUATION ADDICTION:

Alcohol _____ Depressants _____ Stimulants _____ Narcotics _____

If YES, please explain: _____

PPD/Mantoux (required): Date placed _____ Date read _____ Results _____

***** If QUANTIFERON blood test, please supply the lab work* _____

Chest X-Ray (required for positive PPD/Mantoux) _____

Rubella Titer if negative, must have immunization _____

Rubella Immunization _____

Measles Titer if negative, must have immunization _____

Measles Immunization _____

Tetanus (within 10 years) _____

Diphtheria/Tetanus (within 10 years) _____

Hepatitis Vaccine (not required) _____

Based on health history, physical exam, and/or laboratory test(s) performed, this person is free from a health impairment, which is of potential risk to children/families or which might interfere with the performance of his/her duties.

DATE OF EXAM: _____

Doctor's Signature/Stamp WITH License, address, and phone number

CONFIDENTIAL ANNUAL SELF-HEALTH ASSESSMENT

TUBERCULIN SCREENING QUESTIONNAIRE

TO BE COMPLETED BY THE PROVIDER

This form is a screening tool for purposes of employment. It is not suitable for obtaining regular medical examinations and care by your personal healthcare professional.

Name: _____ Date: _____

Address: _____ Phone (home/cell): _____

Email address: _____

Department: _____ Title: _____

Emergency Contact: _____ Relationship: _____ Telephone:_____

1. Since your last medical assessment/physical, have you had any change in your medical status? No ☐ Yes ☐

2. Within the past year, have you had any of the following:

Injury	No ☐ Yes ☐	Asthma/Bronchitis	No ☐ Yes ☐	Back pain	No ☐ Yes ☐
Epilepsy	No ☐ Yes ☐	Fainting spells	No ☐ Yes ☐	Musculo-skeletal	No ☐ Yes ☐
Surgery	No ☐ Yes ☐	Heart trouble	No ☐ Yes ☐	Hernia	No ☐ Yes ☐
Jaundice	No ☐ Yes ☐	Migraine headaches	No ☐ Yes ☐	Arthritis	No ☐ Yes ☐
Sinus Trouble	No ☐ Yes ☐	Skin disease	No ☐ Yes ☐	Thyroid disease	No ☐ Yes ☐
Allergies	No ☐ Yes ☐	Chronic cough	No ☐ Yes ☐	Chronic infections	No ☐ Yes ☐
Nervous disorder	No ☐ Yes ☐	High blood pressure	No ☐ Yes ☐	Digestive disorder	No ☐ Yes ☐
Diabetes	No ☐ Yes ☐	Kidney disease	No ☐ Yes ☐	OTHER:	No ☐ Yes ☐

If yes to any of these, please describe: _____

Tuberculin Screening Questionnaire

1. Have you received a prior diagnosis of active TV or latent TB infection or a positive skin test or blood test for TB? No ☐ Yes ☐

2. Have you been treated for latent TB Infection: No ☐ Yes ☐

3. Have you been treated with medication for TB or for a positive TB test? No ☐ Yes ☐

4. Within the past year, did you have any of the following:

No ☐ Yes ☐ 1) History or temporary or permanent residence (for >1 month) in a country with high TB rate: (i.e. any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe)

No ☐ Yes ☐ 2) Current or planned immunosuppression; including human immunodeficiency virus infection, receipt of organ transplant, treatment with an TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steriods (equivalent of prednisone>15mg/day for >1month) or other immunisuppressive medications;

No ☐ Yes ☐ 3) Close contact with someone who has had TB disease.

5. Within the past year, did you have any of the following symptoms?

Chronic cough	No ☐ Yes ☐	Night sweats	No ☐ Yes ☐	Weight loss	No ☐ Yes ☐
Fatigue	No ☐ Yes ☐	Fever	No ☐ Yes ☐	Loss of appetite	No ☐ Yes ☐

I certify to the best of my knowledge that I am free from any health impairment that may be of any potential risk to the patient or may interfere with the performance of my duties, including habituation or addiction to depressants, stimulants, narcotics, alchohol or other drugs or substances that may alter my behavior. I also certify that the information on this form is accurate.

Provider's Signature: _____

This section to be completed by a Physician, Nurse Practitioner, Physician's Assistant or RN:

Requires further evaluation or followup TB test indicated? No ☐ Yes ☐

Name of Examining Medical Provider or RN Reviewer: _____

Signature: _____ Title: _____ Date: _____