

TRIFORM CAMPHILL COMMUNITY CO-WORKER HEALTH EXAMINATION RECORD

NAME: _____ **DOB:** _____ **DATE of EXAM:** _____

Address: _____ **Telephone:** _____

I have read this form and declare that I have no injury, illness, or ailment other than specifically noted herein. I do understand that any falsification or misrepresentation will be addressed and may result in disciplinary action.	Applicant Signature: _____ Date: _____
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CO-WORKER TO ANSWER: (Note *DETAILS* for Any "Yes" Answers)

	Yes	No		Yes	No		Yes	No		Yes	No
Operations	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	Mental Disease	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>
Fractures	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Head Injury	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Back Injury	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
									Chronic Back Pain	<input type="checkbox"/>	<input type="checkbox"/>

DETAILS:

(Please use the back of the page if more space is needed.)

TB SCREENING:

Unexplained Fever? <input type="checkbox"/> Yes <input type="checkbox"/> No Weight Loss? <input type="checkbox"/> Yes <input type="checkbox"/> No Persistent Cough? <input type="checkbox"/> Yes <input type="checkbox"/> No	Loss of Appetite? <input type="checkbox"/> Yes <input type="checkbox"/> No Fatigue? <input type="checkbox"/> Yes <input type="checkbox"/> No Spitting Up Blood? <input type="checkbox"/> Yes <input type="checkbox"/> No Night Sweats? <input type="checkbox"/> Yes <input type="checkbox"/> No	Close Contact With A Person Testing Positive for TB? <input type="checkbox"/> Yes <input type="checkbox"/> No
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IS THERE A HISTORY OF HABITUATION OR ADDICTION TO ALCOHOL, DEPRESSANTS, NARCOTICS OR OTHER SUBSTANCES THAT MAY ALTER BEHAVIOR? Yes No

Attach a copy of your **immunization record** which must contain vaccinations for Polio, DT, MMR, and an Adult Tetanus Booster that is current or less than 10 years old. *A current **PPD/ TB Screen** (within the last year) is mandatory.

PHYSICIAN TO COMPLETE: B/P _____ HR _____ Temp _____ HT _____ WT _____

SYSTEM REVIEW

EARS: _____

EYES: _____

TEETH: _____

NOSE/ THROAT: _____

SKIN: _____

HEART: _____

LUNGS: _____

ABDOMEN: _____

HERNIA: _____

EXTREMITIES: _____

ALLERGIES: _____

OTHER: _____

WOULD YOU RECOMMEND THIS PERSON FOR EMPLOYMENT? Yes No

DRUG SCREEN REQUIRED? Yes No

If Yes, Explain: _____

*PPD Date _____ Date Read _____

RESULTS: POS NEG IND _____ mm

If PPD positive do **TB Screen & Chest Xray**

If applicable: **CXR** Date _____ POS NEG

PRINT Physician's Name: _____

Address: _____

Telephone: _____ FAX: _____

Signature: _____

License Number: _____ Date _____