**name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_ AGE \_\_\_\_\_\_\_\_

height: \_\_\_\_\_ weight: \_\_\_\_\_ blood pressure: \_\_\_\_\_\_\_\_ PULSE\_\_\_\_\_\_\_ LMP\_\_\_\_

I **Physical Exam** Normal Abnormal Comments

Vision

Hearing

Cardiovascular

Respiratory

Neuromuscular

Endocrine

Gastrointestinal

Orthopedic (low back)

**Result of Hepatitis screening:** **(Optional for work in MH Adult Residential - LTSR programs only)**

❒ Positive ❒ Negative Date of Test: \_\_\_\_\_\_\_\_

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II. tuberculosis screening - Mantoux Test - PPD - required by state regulations

date PPD given: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date PPD read: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PPD **results:** Positive  Negative

PPD results read by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**\*positive test results require a chest x-ray**

Chest X-Ray Results:

Positive  Negative  Asymptomatic history  x-ray Date: \_\_\_\_\_\_\_\_\_

***NOTE: Please use comment section to explain no answers below***

III. **Does this individual have any special medical condition which might interfere**

**with the health of the clients/residents or which might prohibit the individual from**

**performing the functions of the position for which they were hired?**

YES  NO  Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is Individual free of communicable disease?**

YES  NO  Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is Individual clear for work?**

YES  NO  Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider/Physician’s Name (printed)** **Provider/Physician’s Signature**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Provider/Physician’s License # Telephone Number**

**Exam Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_