**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: \_\_\_\_\_\_\_\_

~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~~

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:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_