**Intellectual Gift, Inc. - 1854 Hylan Blvd, 2 Floor, Staten Island, NY, 10305**

**Annual Health Assessment (Physical examination)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RN/LPN/PT/OT/COTA/CSW/SLP/SI

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security # : \_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# Past Medical /Psychological History

*Tuberculosis: no( ) Yes( )*

*Diabetes: no( ) Yes( )*

*Heart or Cardiovascular Disease: no( ) Yes( )*

*Hypertension: no( ) Yes( )*

*Cancer: no( ) Yes( )*

*Kidney Disease: no( ) Yes( )*

*Allergies: no( ) Yes( ) If yes, state\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Epilepsy or Seizure disorder: no( ) Yes( )*

*Drug/Alcohol abuse or addiction: no( ) Yes( )*

*Psychiatric or Behavioral Disorder: no( ) Yes( )*

*Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are you now taking medications? If so, for what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Examiner, please complete the following:**

1. **Mandatory Immunizations and Lab tests. Exact titre number must be given as requested.**

*Diphtheria \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Unless given in the last 10 years)*

*Tetanus \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Unless given in the last 10 years)*

#### PPD(Mantoux)\_\_\_\_\_\_\_\_\_\_\_\_Date \_\_\_\_\_\_\_\_\_\_\_\_\_Results:\_\_\_\_\_\_\_\_date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Rubella titre\_\_\_\_\_\_\_Or screen\_\_\_\_\_\_\_\_\_\_\_\_date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Results: ( ) immune ( ) not immune ( ) rubella vaccine (If needed):\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

## Rubeola titre\_\_\_\_\_\_\_Or screen\_\_\_\_\_\_\_\_\_\_\_\_date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Results: ( ) immune ( ) not immune ( ) rubeola vaccine (If needed):\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Hepatitis B: ( ) immune ( ) not immune ( ) immunization contraindicated*

*Vaccine dates:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

### III. Lab Tests

*CBC: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ results\_\_\_\_\_\_\_\_\_\_date\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Urinalysis:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_results\_\_\_\_\_\_\_\_\_\_date\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**\*\*\* Chest X -RAY Mandatory if PPD (MANTOUX) is positive!!!**

1. **Review of Systems by Examiner:**

*Head/Neck \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

## EENT \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*Resp. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

## Cardiovasc. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*ABD - GI \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*GU \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Musc-skel \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Neuro \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Endocrine \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Skin \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

1. **Medical Examiner:**

***I hereby certify that the above named patient does not have any limitations for employment in the health care field and contract with patient and other staff. There is no health impairment present that is of potential risk to the employee, patient, family or other employees, or that may interfere with the performance of duties.***

***Physician’s signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Physician’s name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

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

***Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_***

**Intellectual Gift, INC.**

**1854 Hylan Blvd, 2 Floor,**

**Staten Island, NY, 10305**

**(718) 524-7995**

Employee’s Name: Title: 

# HEPATITIS B VACCINE CONSENT / DECLINATION

## I acknowledge that I am at risk of exposure or have been unknowingly exposed to the Hepatitis B virus as a result of my employment and acknowledge that the agency will arrange for me receive the Hepatitis B vaccine. I have read the information sheet concerning the disease, the vaccine and possible adverse reactions to the inoculation. Additionally, I have asked any questions which I may have had and they have been fully answered to my satisfaction. I hereby make the decision to:

request that I receive the Hepatitis B vaccine

refuse the Hepatitis B vaccine and hold harmless the agency. I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine, at no charge to myself. However, I decline the Hepatitis B vaccination at this time. I understand that by declining the vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and want to be vaccinated with the Hepatitis B vaccine, I can receive the vaccination series at no charge to me.

provide written proof of immunity (attach supportive documentation)

provide written proof of previous vaccination (attach supportive documentation)

provide written proof of medical contraindication (attach supportive documentation)

Signature: Date:

Supervisor or witness:

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