PACKER EMPLOYEE HEALTH FORM CHECKLIST

HEALTH FORM PROCEDURE

☐ Have a Physical Exam and bring the health form to your physician.
☐ Complete, sign, and date all areas on page 1 of your health form.
☐ Include current emergency contacts. (Who should we call if you become ill or injured at Packer?)
☐ Include your immunization documentation if your physician does not have documentation.
☐ Made a copy of your completed health form for your records.
☐ Submit your completed employee health form to the Nursing Office.
☐ Get a PPD only if you are a new employee.

PLEASE MAKE SURE YOUR HEALTH CARE PROVIDER HAS:

☐ Entered all requested medical information on the back of your health form.
☐ Submitted documentation of all your immunizations and screening test results.
☐ If immunizations record is unavailable, ordered blood titers for infectious diseases noted on the back of the health form.
☐ Administered the P.P.D./Mantoux test. (Nurse or MD reads test within 48-72 hours.)
   (ONLY FOR NEW EMPLOYEES)
☐ Administered Tetanus Toxoid Booster within the past 10 years. (Tdap)
☐ Completed, signed, and dated the back of your health form.
The Packer Collegiate Institute
Personnel Health Form
Nursing Office Telephone 718 250-0259; Fax 718 250-0292

Instructions: Employees complete this side; physician completes reverse.

**Name**
Last, first, middle

**Address**
Street, city, state and zip code

**Telephone**
Area code and number

SEX: ☐ Male ☐ Female

Date of Birth: __/__/___

Date of Employment __/__/___

Division or Department: _______________________

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**MEDICATIONS**

What medications does your physician prescribe for you?

- Asthma
- Diabetes
- History of fractures (specify)
- Heart disease
- Hypertension
- Hypoglycemia
- Ligament/Skeletal injuries

What over-the-counter medications do you take? Please record them in order for the nurse to administer.

**YOUR HEALTH HISTORY**

Please check all that apply

- Seizure disorder
- Surgery (specify)
- Other (specify)

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**ALLERGIES:** Please list all food, drug and environmental allergies. Describe the symptoms you experience.

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**EMERGENCY CONTACTS:** Please update when changes occur

<table>
<thead>
<tr>
<th>Name</th>
<th>Relationship</th>
<th>Address</th>
<th>Email</th>
<th>Home phone</th>
<th>Work phone</th>
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<tbody>
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**PERSONNEL CONSENT FOR EMERGENCY MEDICAL TREATMENT**

I authorize The Packer Collegiate Institute staff to obtain emergency treatment for me. I understand my emergency contact person(s) will be notified as soon as possible. I authorize Packer to take care of me if I become ill or injured. I authorize Packer to contact my health care provider in case of an urgent health care condition occurring during working hours and to obtain Personnel Health Form information.

Signature ________________________ Date ___________

* Notify the Nursing Office immediately of any changes in contact information

Rev. 8/06 Medomak Graphics 207 832-7412
# Physicians’s Report

*(Please complete this entire page, date and sign)*

<table>
<thead>
<tr>
<th>SCREENING TESTS</th>
<th>Date Done</th>
<th>Results</th>
<th>Not Done</th>
<th>IMMUNIZATIONS</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tuberculosis testing Mantoux P.P.D.</td>
<td></td>
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<td>Required to have documental titers for immunizations</td>
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<td>Rubeola</td>
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<td></td>
<td></td>
<td>Rubella</td>
<td></td>
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<tr>
<td>Other</td>
<td></td>
<td></td>
<td></td>
<td>Mumps</td>
<td></td>
</tr>
</tbody>
</table>

**If history of positive P.P.D.:**
- Date of positive P.P.D.: __________
- Date of last chest X-ray: __________
- Results: __________
- Treatment for past positive P.P.D.:
  - Rx __________ Date: __________
  - Rx __________ Date: __________

**Vision Screening**
- Problems __________
- Date of screening __________

**Hearing Screening**
- Results __________
- Date __________

**Other:**
- BCG

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**Physical Examination** *(include all findings)*

- Height: ______
- Weight: ______
- Blood pressure: ____/____
- Pulse: ______

**Prescribed Medications** *(include daily and emergency Rxs)*

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**Allergies**

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**Diagnoses and Treatments**

1. ____________________________
2. ____________________________
3. ____________________________

**RESTRICTIONS:**

May perform job duties safely. Over-the-counter medication administration is approved, when requested by employee.

**Signature of health care provider** Date

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**Physician’s/Provider’s stamp** *(must be included)*

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**Name of health care provider (please print)**

**Telephone**

**Fax number**