PACKER EMPLOYEE HEALTH FORM CHECKLIST

HAVE YOU:

☑ Completed, signed, and dated all areas on the front of your health form?
☑ Included current emergency contacts information should you become ill or injured at Packer?
☑ Made an appointment for your physical examination?
☑ Remembered to bring the health form to your physician for completion?
☑ Included your immunization documentation if your physician does not have documentation?
☑ Made a copy of your completed health form for your records?
☑ Submitted your completed employee health form to the Nursing Office?

HAS YOUR HEALTH CARE PROVIDER:

☑ 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.)
☑ Administered Tetanus Toxoid Booster within the past 10 years?
☑ 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: ____________________

MEDICATIONS
What medications does your physician prescribe for you?

Asthma

Diabetes

History of fractures (specify)

Heart disease

Hypertension

Hypoglycemia

Ligament/Skeletal injuries

Date of onset

Seizure disorder

Surgery (specify)

Other (specify)

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

YOUR HEALTH HISTORY
Please check all that apply

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

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.

* EMERGENCY CONTACTS: Please update when changes occur

Name
Relationship
Address
Email
Home phone
Work phone

Name
Relationship
Address
Email
Home phone
Work phone

* 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)

Name: ____________________________ Date of Birth: __________________

<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</td>
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<td>Required to have documental titers</td>
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<td>Mantoux P.P.D.</td>
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<td>for immunizations</td>
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<td>Varicella</td>
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<td>Tetanus Toxoid (every ten years)</td>
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<td>Specify dose: Adult/Peds</td>
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<td>Hep. B¹</td>
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<td>BCG</td>
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</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 _________

Eyeglasses ______________

**Hearing Screening**

Results ______________

Date __________

**Physical Examination** (include all findings)

Height: _______

Weight: _______

Blood pressure: ___/___

Pulse: _______

**Prescribed Medications**

(include daily and emergency Rxs)

**Allergies**

**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

**Physician’s/Provider’s stamp**

(must be included)

Name of health care provider (please print)

Telephone

Fax number