AUTHORIZATION FOR HEALTH SCREENING

I hereby authorize CMHHIFL's Employee Health Department to perform a health screening which includes a general health history (included in this packet), tuberculosis testing (if needed), fit testing for an N95 mask, and administration of select vaccines as necessary.
I understand that the information obtained from the health screening is confidential and will not be disclosed or reported to any person within or outside the workplace, without the employee's expressed written consent, except as required by State or Federal law.

Name (printed): _____

Dept./Agency/Job Title: _____

Employee's Signature: _____ **Date:** _____

CMHHIFL Health Inventory

One way to eliminate the risk of persons being assigned into placements that would pose undue risk of infection or injury to themselves, to their personnel, or to visitors, is to complete a health inventory. All medical information will be kept *strictly confidential*. Only with your permission will those conditions which could affect job performance, be shared with your supervisor. Once completed, the Employee Health Coordinator will review this form with you. Feel free to ask questions you may have about your health and safety at CMHHIFL.

Full Legal Name:
Date of Birth:
Home Address:
County, Zip Code:
Personal Phone #:
Personal Email:

CAUTION: This Screen is not intended to be all-inclusive. Individuals, who are uncertain whether they are, or may have sensitivities to, natural rubber latex or other allergies that might require you to consult their primary care provider.
NOTE: CMHHIFL is a latex free facility. There may be incidents when the Department of Facilities Management (DFM) or outside vendors bring latex gloves into the facility. If you have an allergy to latex, always check the packaging before using.

This questionnaire should be completed after an offer of employment is completed.

General Health Questionnaire & Allergy Screen

Answer the following questions by indicating **Yes/ No.** If you answer **Yes** to any questions, please explain below.

1. Is there any reason why you would not be able to perform the essential functions of your job?
_____ Yes _____ No

If **Yes**, describe: _____

2. Do you require additional help or support to perform the essential duties of your job?
_____ Yes _____ No

If **Yes**, describe: _____

3. Have you ever been treated for a work injury, or received Worker's Compensation benefits?
____ Yes ____ No If **Yes**, Date of injury _____

If **Yes**, what was the injury? _____

4. Do you have any current or permanent restrictions? _____ Yes _____ No

If **Yes**, describe: _____

5. Do you have any medical or safety questions or matters that you would like to discuss during your health screening? _____ Yes ____ No

If **Yes**, describe: _____

6. Have you ever had a reaction to latex? _____Yes _____No

If Yes, describe the incident & symptoms: _____

_____
(Symptoms may be itching, redness, swelling, hives, runny nose, wheezing, congestion, chest tightness)

7. Are you allergic to any foods, medications, environmental factors? ___Yes ____No

If Yes, list and describe symptoms; _____
(Common symptoms are mouth tingling, lip swelling, itchy throat, runny nose, wheezing, hives or nausea)

8. Do you carry an Epinephrine (EPI) pen with you? _____Yes _____No

9. Do you have a history of any of the following conditions? _____Yes _____No

Contact Dermatitis ____ Eczema ____ Asthma____ Autoimmune disease (Lupus, etc) ____

Hay fever ____

Hepatitis B Vaccine Evaluation

Your position in the "at risk" category of being exposed to blood or body fluid

1. *Have you had a Hepatitis infection in the past? Yes ____ No ____*
2. *Have you received the Hepatitis B vaccine in the past? Yes _____ No ____*

*If Y**es**, list number of doses received or last titer (blood draw) date, **if known**?* _____

*The date of the last dose, **if known**?* _____

Hepatitis B VACCINE DECLINATION Section

* If you have already received the Hepatitis B Vaccine and have a copy of the documentation, please send it with this completed packet. Documentation is preferred, but is not required. This is why this mandatory declination section is in place.

Declination Statement:

- I understand that due to my occupation, exposure to blood or other potentially infectious materials is possible. Therefore, I may be at risk of acquiring the Hepatitis B virus (HBV) infection.
- I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, if I have not received the vaccine previously.
- If, in the future, I have an occupational exposure to blood or other potentially infectious materials and I wish to be vaccinated with the Hepatitis B vaccine, I understand that I can receive the vaccination at no charge.

Attestation Statement:
I am signing this declination because either I already received the vaccine or do not wish to receive it at this time.

Only Sign If:

You previously received the Hepatitis B vaccine or blood titer confirming immunity.
Or you are not interested in receiving the Hepatitis B vaccine.

Employee's Signature: _____

Name: _____ Date: _____

CMHHIFL Witness: _____ Date: _____

Note: If you have questions about the Hepatitis B Vaccine, please let the CMHHIFL Employee Health Nurse know. The vaccine is available at CMHHIFL and is free of charge.

Tuberculosis Screening Risk Assessment CONFIDENTIAL

_____ Date Form Completed ___/___/_____
Last Name First Name Middle Initial Mo Day Yr

Signature: _____

1. **Were you born in the United States?** [ ] **Yes** [ ] **No**

   a. If no, what is your country of birth? _____
      1. b. What year did you move to the U.S.A.? _____ [ ] **Unknown**

2. **Have you traveled or lived outside the United States in the last 2 years?** [ ] **Yes** [ ] **No**

   If **Yes**, where? _____

3. **Date of last TB skin test, blood test, or chest x-ray? Date**_____/_____/_____

   a. What was the test result? [ ] Positive [ ] Negative [ ] Unknown

   b. If yes, did you receive treatment and what **medication(s)** were you prescribed?

      [ ] Isoniazid (INH) [ ] Other _____ [ ] Unknown [ ] No treatment

4. **Have you ever received a BCG vaccine?** [ ] Yes, If **Yes** (year):_____ [ ] No [ ] Unknown
   (Receipt of a BCG vaccine is not a contraindication to placement of a skin test and may not affect the results of the BCG was received > 1 year ago)
   a. Have you ever had a positive test or told you have latent TB? [ ] Yes [ ] No
   b. If yes, did you receive treatment and what **medication(s)** were you prescribed?

      [ ] Isoniazid (INH) [ ] Other _____ [ ] Unknown [ ] No treatment

5. **Has a health practitioner ever told you that your immune system isn't working right or can't fight infection?** [ ] **Yes** [ ] **No** [ ] **Unknown**

6. **The conditions listed below can make people more susceptible to developing active TB.**
   ·HIV infection ·Treatment with Remicade or Enbrel ·Diabetes Mellitus ·Silicosis
   ·Chronic Alcoholism ·Chronic malabsorption syndrome ·Chronic peptic ulcer disease
   ·Chronic Renal Failure ·End-stage Renal Disease ·Gastrectomy & jejunoileal bypass
   ·Prolonged therapy with steroids Immunosuppressive therapy
   ·Hematologic disorder such as leukemia's & lymphomas ·Specific cancers such as head & neck
   ·Weight loss greater than 10 percent below ideal body weight

7. **Do you have any of the conditions listed above? [ ] Yes** [ ] **No** [ ] **Unknown**

8. **Have you recently experienced any of the following symptoms that have lasted for several weeks? (Please check all that apply)**

   [ ] Persistent coughing **[ ]** Excessive fatigue **[ ]** Coughing up blood **[ ]** Hoarseness **[ ]** Excessive sweating at night **[ ]** Excessive weight loss **[ ]** Persistent fever

   [ ] None of the above

Do not write below this line: CMHHIFL Employee Health Nurse Recommendations

1. Low risk of active TB infection & Latent TB infection is not suspected Tuberculosis Skin Test recommended _____
2. History of positive TB test or BCG vaccine _____If **Ye**s must complete Annual Risk assessment
3. Referral to the Denver Health Tuberculosis Clinic ____Education given to staff with new or existing positive tests_____

COLORADO
Department of Human Services
Colorado Mental Health Hospital in Fort Logan

TB PPD Skin Test

[ ] New Hire **[ ] Post Exposure** **[ ] Other_____**

Name (printed): _____ **Dept./Job Title:** _____

History – *Please circle **Yes** or **No***

1. Have you ever had a POSITIVE TB skin test?	Yes	No
2. Have you ever been advised not to receive additional TB skin tests because you are allergic to the products from which it is made?	Yes	No
3. Have you ever received a BCG vaccine (given during childhood in other countries)?	Yes	No
4. Have you had any "serious" viral infections or received any vaccines within the past 6 weeks?	Yes	No
5. Have you received immunoglobulin (IG) within the last 5 months?	Yes	No
6. Have you taken any steroids or cancer medications within the past 6 weeks?	Yes	No

Employee Signature: _____ **Date:** _____

THE FOLLOWING TO BE COMPLETED BY CMHHIFL EMPLOYEE HEALTH PERSONNEL ONLY

PPD Testing

TEST #__				
Date & Time Applied:				
Forearm Site (circle one):		L		R
Drug (circle one):	Tubersol		Aplisol	
Lot #:		Exp Date:		
#of Test Units Given:				
CMHHIFL RN Signature:				

TEST #__				
Date & Time Applied:				
Forearm Site (circle one):		L		R
Drug (circle one):	Tubersol		Aplisol	
Lot #:		Exp Date:		
# of Test Units Given:				
CMHHIFL RN Signature:				

PPD Measurement

Test #__
Date & Time Read:
Induration (in mm):
CMHHIFL RN Signature:

Test #__
Date & Time Read:
Induration (in mm):
CMHHIFL RN Signature:

1. If a referral was made to the Denver Tuberculosis Clinic for Further Follow-Up Please Indicate The Date and

Time of Appointment or N/A: _____

2. Was prior TB testing documentation submitted?

COLORADO
Department of Human Services
Colorado Mental Health Hospital in Fort Logan

The above information is accurate and complete to the best of my knowledge. I give consent to CMHHIFL to inform the appropriate health authorities of a communicable disease discovered. I also understand that this medical evaluation is for employment purposes only and is not to be considered as an all-inclusive physical examination.

Employee's Signature: _____ **Date:** _____

Health Screening completed by CMHHIFL Employee Health RN

Name (printed): _____

Signature: _____ Date: _____
