2024 THE HAGEDORN LITTLE VILLAGE SCHOOL 2024

750 Hicksville Road, Seaford, NY 11783 Phone Number (516) 520-6000 Fax Number (516) 520-6084

INITIAL HOME BASED Health Form and Medical Statement

SECTION A - ALL PROVIDERS COMPLETE

***** CIRCLE THE DEPARTMENT(S) THAT APPLIES TO YOUR POSITION: EI CPSE/CSE *****

Name _____

Address _____ City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____

DOB _____ Position _____

I hereby certify that to the best of my knowledge, I am not currently exhibiting signs of a communicable disease or symptoms suggestive of an emotional or psychiatric disorder that would hinder my job performance working with children with special needs or that would pose a risk to the health and safety of the children in my care. Further, I am physically able to perform the job duties of my position. I attest that I have not forged or altered any information contained in this document or attached to this document. I am aware that the submission and/or possession of forged or altered documents may constitute a crime.

Signature_____Date_____

SECTION B - ALL PROVIDERS COMPLETE

THE SECTION BELOW MUST BE COMPLETED AND SIGNED BY A MD, PA, NP OR RN

EI ONLY: If you elect the Mantoux TB Test option, you MUST submit a 2nd Mantoux TB test within 90 days.

Mantoux (skin test for tuberculosis) Date PPD Placed: _____ Location - Right Arm ☐ Left Arm ☐

Date PPD Read: _____ Please check one: Negative ☐ Positive ☐

OR

QuantiFERON GOLD Date administered _____ Results check one: Negative ☐ Positive ☐

⇨ **If positive, does this person's contact with children pose a risk to children's health and safety? Yes ☐ No ☐**

⇨ **If previously positive, provide date _____**

⇨ **If prior positive PPD, submit proof that a chest X-ray was completed and clear and that there is a clinical assessment by healthcare provider for no active TB ☐**

⇨ **If PPD not completed – provide reason _____**

Healthcare provider's Signature _____ Date _____

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Name: _____

SECTION C - ALL PROVIDERS COMPLETE

IMMUNIZATIONS: Please submit complete titers lab results for the following:

Rubella: Results of Titer positive/negative _____ **or** Immunization Date _____
Measles :Results of Titer positive/negative _____ **or** Immunization Date _____
Mumps: Results of Titer positive/negative _____ **or** Immunization Date _____

SECTION D - ALL PROVIDERS COMPLETE

DOH Highly Recommended Vaccinations	Date Received	Patient Declined (MUST initial)
Hepatitis B	_____	_____
Tetanus (within last 10 years)	_____	_____
Diphtheria	_____	_____
Pertussis	_____	_____
Varicella (chicken pox)	_____	_____
Influenza	_____	_____
COVID-19	_____	_____

SECTION E - ALL PROVIDERS COMPLETE

THE SECTION BELOW MUST BE COMPLETED AND SIGNED BY A PHYSICIAN, PHYSICIAN'S ASSISTANT OR NURSE PRACTITIONER

Healthcare provider's statement:

I have examined the above named individual and to the best of my knowledge, I find that:
They are not currently exhibiting signs of a communicable disease that would pose a risk to the health and safety of the children in their care. They are not exhibiting signs or symptoms of an emotional or psychiatric disorder, which would pose a risk to the health and safety of the children in their care. They do not have a physical condition that would prevent them from providing typical child day care duties such as lifting and carrying children, direct supervision of children, food preparation, close contact with children, emergency evacuation of children.

Date of Physical Exam _____

Healthcare provider's Signature _____

Healthcare provider's Phone Number _____

Healthcare provider's Name _____

Healthcare provider's Address _____
_____

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SECTION F - EI PROVIDERS ONLY

Tuberculosis Screening and Risk Assessment

NAME: _____ DATE: _____

1. Have you EVER spent more than 30 days in a country with an elevated TB rate? This includes all countries except those in Western Europe, Northern Europe, Canada, Australia and New Zealand.
   a. YES I have been in a foreign country for ≥ 30 days (not including those listed above).
   b. NO I have not been in any country for ≥ 30 days (except the ones listed above).

2. Have you had close contact with anyone who had active TB since your last TB test?
   YES / NO

3. Do you currently have any of the following symptoms:
   a. YES / NO unexplained fever for more than 3 weeks
   b. YES / NO cough for more than 3 weeks with sputum production
   c. YES / NO bloody sputum
   d. YES / NO unintended weight loss ≥ 10 pounds
   e. YES / NO drenching night sweats
   f. YES / NO unexplained fatigue for more than 3 weeks

4. Have you ever been diagnosed with active TB disease?
   YES / NO

5. Have you ever been diagnosed with latent TB infection *or* had a positive skin test *or* a positive blood test for TB?
   a. YES one or more of these is true for me
   b. NO none of these is true for me

6. Have you ever been treated with medication for TB *or* for a positive TB test (eg, taken "INH")?
   YES / NO
   IF YES, what year, with which medication, for how long, and did you complete the treatment course?
   _____

7. Do you have a weakened immune system for any reason including organ transplant, recent chemotherapy, poorly controlled diabetes, HIV infection, cancer, or treatment with steroids for more than 1 month, immune-suppressing medications such as a TNF-alpha antagonist or another immune-modulator? (If you are not sure, ask your Occupational Health Provider.)
   YES one or more of these is true for me
   NO none of these is true for me

   Comments: _____
   _____

Completed and reviewed by Occupational Healthcare Provider (MD, NP, PA, RN)

Name of Healthcare Provider (print):_____

Signature of Occupational Healthcare Provider: _____

Date: _____