2026 THE HAGEDORN LITTLE VILLAGE SCHOOL

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

ANNUAL Health Form and Medical Statement

EMPLOYEE SECTION

Name _____ DOB _____

Cell Phone # _____ 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 _____

PREVIOUS IMMUNIZATIONS RECORD SECTION (HLVS HR)

REQUIRED for the Home-Based EI Program/Providers (Under 3 years of age)

MEASLES: Dose(s) _____ **OR** Results/Dates of **Positive** MEASLES Titer: _____

RUBELLA: Dose(s) _____ **OR** Results/Dates of **Positive** RUBELLA Titer: _____

***If there is NO immunization record available and/or titers are NEGATIVE, a booster date is required:**
Booster date/s: _____

HEALTHCARE PROVIDER SECTION

DOH Highly Recommended Vaccinations	Date Received		Date Unavailable (Employee initials)
Hepatitis B	_____		_____
Tetanus (within the past 10 years)	_____		_____
Varicella (chicken pox)	_____	**OR**	_____
Influenza	_____		_____

Healthcare Provider Statement:

I have examined the above-named individual and to the best of my knowledge, I find that the individual is free from a health impairment which is of potential risk to children/families, or which might interfere with the performance of his/her duties.

Date of Physical Exam: _____

Healthcare Provider Signature: _____

Stamp Required

ANNUAL Tuberculosis Screening and Risk Assessment

TB BASELINE ASSESSMENT – Previous Mantoux Skin Test OR QuantiFERON GOLD bloodwork

Name _____ DOB _____

Previous Negative TB test date: _____ **OR** **Date of negative chest X-ray:** _____

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 has 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, add in the comments, 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?
   a. YES, one or more of these is true for me
   b. NO none of these is true for me

Comments: _____

Date of TB Risk Assessment: _____

Healthcare Provider Signature: _____

Stamp Required