PALOMAR HEALTH
Employee Health & Safety

Annual Health Evaluation

Name (Last, First, Middle)	**Employee ID**	**Birthdate** (Mo /Day / Yr)
Employer	**Position**	**Date**

For questions below, please use space below to explain any yes answers.

1. Have you changed jobs/positions in the past 12 months	☐ Yes ☐ No
2. Are you taking any medications?	☐ Yes ☐ No
a. If yes, please list *all* medications below, including over-the-counter medications.	
3. Do you have any active medical / orthopedic problems in the past year?	☐ Yes ☐ No
4. Do you have any medical / post-surgical condition(s) that affect the ability to perform your job?	☐ Yes ☐ No

Explanations to "Yes" Answers [Place the question # and your explanation(s) below]

Question #	**Explanation**	**Clinician Comment** ***Employee Health staff use only***

VITALS: ☐ **Consent** ☐ **Declined** **Initial:** _____

Height _____ (ft', in'') Weight _____ (lbs.) Temp _____ (^{o}F) Pulse _____ BP _____/_____

IMMUNIZATIONS RECOMMENDED: ☐ Hep A ☐ Hep B ☐ Varicella ☐ Td ☐ Tdap ☐ Measles ☐ Mumps ☐ Rubella ☐ Influenza ☐ Titers _____

Vaccination Declination Statement: The employer shall ensure that employees who decline to accept a recommended vaccination offered by the employer sign and date the following statement as required by subsection (h)(5)(E): ***A declination will be signed for each declined vaccine – Hepatitis B, MMR, Td/Tdap, Influenza and Varicella in accordance with the CalOSHA ATD Standard and Procedure 11788 Vaccines for Healthcare Personnel.***

☐ Hepatitis A (Hep A) ☐ Hepatitis B (Hep B) ☐ VARICELLA (Chicken Pox)
☐ Td (Tetanus Diphtheria) ☐ Tdap (Tetanus, Diphtheria & Pertussis)
☐ Measles, Mumps, Rubella (MMR) ☐ Influenza

I have been given the opportunity to be vaccinated against these disease/pathogens above at no charge. However, I decline the checked vaccination(s) at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring these disease/pathogens above. If in the future, I continue to have occupational exposure to aerosol transmissible diseases and want to be vaccinated, I can receive the vaccination at no charge to me.

_____	_____	_____
Name (print)	**Employee Signature**	**Date**

EMPLOYEE HEALTH CLINICIAN

_____	_____
Employee Health Clinician Signature	**Date**

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Tuberculosis Symptom Questionnaire

Name: _____ **ID #:** _____ **Birth Date:** _____

In the past year, have you experienced any of the following symptoms **NOT** associated with a specific illness (i.e. cold or flu) and lasting more than 3 weeks?

	Yes	No	Comments
Cough	☐	☐	_____
Blood Streaked Sputum	☐	☐	_____
Unplanned Weight Loss	☐	☐	_____
Night Sweats **(excluding Menopause)**	☐	☐	_____
Fever	☐	☐	_____
Have a condition or take medications which affect your immune system (i.e. steroids)?	☐	☐	_____

****PLEASE NOTE: If you have a suppressed immune system, you will need a TB Skin Test (TST). TST's are offered Mon, Tue, Wed, & Fri. The TST will need to be placed AND read before your annual is considered complete.**

Signature: _____ Date: _____

Employee & Corporate Health Use ONLY:

☐ PH Employee ☐ Corporate
☐ Medical staff ☐ Volunteer
☐ Contracted Staff ☐ Pathmaker

1. Client meets criteria for QFT TB screening?
- ☐ Yes
- ☐ No (DO TST)

2. PPD: Tubersol (0.1 ml 5TU Intradermal) Lot: _____ Exp: _____

Date Placed: _____ Site: _____ Given by: _____

Date read: _____ Induration: _____mm Read by: _____

2-step required: ☐ No ☐ Yes (PPD: Tubersol 0.1 ml 5TU Intradermal) Lot: _____ Exp: _____

Date Placed: _____ Site: _____ Given by: _____

Date Read: _____ Induration: _____mm Read by: _____

PPD Conversion date: _____ PPD _____mm Chest X-ray Date: _____ Results _____

QFT Conversion date: _____ QFT _____ Chest X-ray Date:_____ Results _____

Clearance

☐ MEDICALLY CLEARED FOR WORK

☐ FURTHER EVALUATION REQUIRED

_____

_____

_____

Clinician Signature: _____ **Date:** _____

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OSHA Respirator Questionnaire

(Not to be used for initial screening)

Name (Last, First, Middle)	**Employee ID**	**Birthdate** (Month / day / year)
Department	**Position**	**Date**

Respirator Evaluation Questions

Please answer the following questions since your last fit test and respirator clearance evaluation:

1. Have you developed any medical problems or symptoms that may limit your ability to wear a N95 respirator? ☐ Yes ☐ No

2. Have you been told by a health care professional, your supervisor, or the respirator program administrator that you should be medically reevaluated? ☐ Yes ☐ No

I understand it is my responsibility to report to Employee Health Services of any change in health status that may affect my ability to safely use a respirator. It is also my responsibility to notify my supervisor of the need for Employee Health clearance prior to fit testing, if applicable.

Employee Signature: _____ Date: _____

Clinician Signature: _____ Date: _____