# EMPLOYEE TUBERCULOSIS SURVEILLANCE RECORD

| LAST NAME | FIRST NAME | MALE FEMALE |
|---|---|---|
| **BIRTHPLACE** | | POSITION |
| Known Contact to TB<br>Date / Extent of Exposure: | | |

| **TUBERCULIN TEST** | | **ANNUAL QUESTIONAIRE** | **CHEST X-RAY** | |
|---|---|---|---|---|
| DATE | RESULT | DATE FINISHED | DATE | RESULT |
| | | | | |
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**TB Screening Questionnaire** **CONFIDENTIAL** **Annual/Post-exposure**

| Name Date of Birth | Date Form Completed |
|---|---|
| Job Title | Last TB Skin Test (PPD) Date and Result |
| Last Chest X-Ray Date Result in File ☐ | Bacillus Calmette-Guérin (BCG) Vaccinated in the past. **YES** ☐ **NO** ☐ |

***** Please put "X" if you are having any of the following problems for over TWO weeks at a time.**

| | |
|---|---|
| ☐ Persistent coughing | ☐ Coughing up blood for any duration |
| ☐ Hoarseness | ☐ Fatigue/Tiredness |
| ☐ Unexplained excessive weight loss | ☐ Chest Pain/Shortness of Breath |
| ☐ Night sweats | ☐ Fever/Chills |

| | **YES** | **NO** |
|---|---|---|
| Since your last TB skin, have you worked in a location where patients with active TB received care or services? | | |
| Since your last TB skin test, have you had close contacts with someone who has active TB disease? | | |
| Since your last TB skin test, have you had an abnormal chest x-ray? | | |
| Since your last TB skin test and/or has a health practitioner told you that your immune system isn't working right or can't fight infection? | | |
| Since your last TB skin test, have you traveled outside US since last skin test? | | |
| Comments | | |

**Signature:**_____**Date:** _____

# EMPLOYEE HEALTH RECORD

**Please indicate with an (X) if you have any of the following:**

| | | | | | |
|---|---|---|---|---|---|
| | Severe Headache | | Chest Pain/Pressure | | Bowel Problems/Hernia |
| | Vision Impairment | | Varicose Veins | | Menstrual Difficulties |
| | Hearing Difficulties | | Hepatitis | | Venereal Disease |
| | Speech Impairment | | Heart Problems | | Diabetes |
| | Fainting/Dizzy Spells | | High Blood Pressure | | Kidney Problems/Disease |
| | Allergy/wheezing/asthma | | Low Blood Pressure | | Skin Allergies/Disease |
| | Frequent Colds | | Back Problems | | Alcoholism/Drug Addiction |
| | TB/Any Communicable | | Arthritis/ Bone Problem | | Nervous Breakdown |
| | Chronic Coughing | | Stomach | | Allergies |

| | |
|---|---|
| A. Are you under the care of a physician? Y / N | B. Are you taking any medication? Y / N |
| C. Have you had operation/ been hospitalized? Y / N | D. Have you had any serious accident? Y / N |

If you answered YES to any of the above, please explain: _____

If required in your position, would you be willing to have screening test for drug/alcohol done on your blood/urine as a condition of employment: _____Yes _____ No

I hereby give my permission to release the results of any test and/ or information regarding my health status to Friends Health Care Team I understand that I must provide the result of the annual PPD test if negative to retain active employment with Friends Health Care Team. I am willing to provide vaccination record if requested.

Signature: _____ Date: _____

## EMPLOYEE HEPATITIS B VACCINAITON CONSENT/REFUSAL FORM

**Facts**: Hepatitis B is one of several viral infections of the liver that can cause severe illness and even death. Hepatitis B is a bloodborne pathogen. Sources of exposure include any skin or mucous membrane exposure to blood, semen, vaginal secretions, cerebral spinal fluid, synovial fluid, plural fluid, pericardial fluid, amniotic fluid or other body fluids if they contain visible blood. The most common methods of exposure are needle sticks, cuts with bloody equipment or splashes of blood or infected material (including raw sewage) into a mucous membrane. Anyone who has an exposure risk to any of the above listed fluids needs to strongly consider the HBV series. The HBV is a synthetic vaccine, contains no substances of human origin and is manufactured using yeast. Adverse reactions to the HBV are rare. The most common side effect is soreness at the injection site. Other side effects include, but are not limited to: fatigue, fever, headache, dizziness, chills, flu-like symptoms, rash, asthma-like symptoms, abnormal liver tests, Guillain-Barre syndrome, Bell's palsy and myelitis.

**I have read and understand the information about the Hepatitis B Virus, the vaccine to prevent the disease. I understand that the HBV series is voluntary.**

□ CONSENT: I understand my risk of BBP exposure and I want to receive the HBV series at this time per Company policy.

□ REFUSAL: I understand my risk of BBP exposure, but I do not want to receive the HBV series at this time. I understand I can change my mind at any time and can begin the HBV series by contacting the office.

□ HBV RECORDS: I have already received the Hepatitis B vaccination previously.

Signature:_____Date:_____

## Waiver of Claim for Injury Clause

I do hereby fully release, hold harmless, discharge and defend Friends Health Care Team. as well as any and all of its officers agents, servants, employees, independent contractors and volunteers from any all claims as a result of disease, death or from injuries, including but not limited to the aggravation of any pre-existing ailment or condition; disability and disfigurement, pain and suffering; medical care, treatment and services; lost earnings, profits and salaries, lost earning capacity; the reasonable expense of necessary help in the home; as any and all property damage I, my spouse or my dependents might sustain arising directly or indirectly out of my refusal to participate in the above- captioned Hepatitis B Vaccination Program.

I have read and fully understand the Waiver, Release of All Claims and Indemnity Agreement. I understand that the terms hereof are contractual and are not a mere recital.

Signature: _____Date:_____

Agency Witness: _____ Date: _____
Signature, title