ADVANCED PROFESSIONAL RESOURCES
Early Intervention Services Birth – Three Years
224 Franklin Avenue, Suite 4
Hewlett, N. Y. 11557
*(516) 791-6200 * Fax: (516) 791-6026*

Provider Medical Form

Name:_____ Date of Birth:_____
Professional Discipline:_____ Phone Number:_____
Address:_____

I hereby certify that I am free of medication, drugs, communicable diseases or medical/emotional problems which would impair job performance

Signature:_____ Date:_____

This section to be completed by physician

Physical Exam:

Height_____ Weight_____
Blood Pressure_____ Pulse_____ Respiration_____
Heart_____ Chest_____

****Required for new employees/contractors as baseline. Otherwise, only TB assessment form is required (see next page)****

PPD T.B Skin Text (Mantoux) _____ _____ _____
Date Placed Date Read Results

If positive: Date of Chest X-Ray _____ Results of Chest X-Ray _____

Immunizations: To be completed by physician

**Required	Date of Vaccine (Date to be completed by physician)	Lab test of immunity (Date to be completed by physician or attach lab work)	Refusal of Vaccination or Lab Test (patient must initial)
Rubella / German Measles**			
Rubeola / Measles**			
Mumps**			
Hepatitis B (3 doses)	1)_____ 2)_____ 3)_____		
Varicella / Chicken Pox			
Diphtheria			
Pertussis / Whooping Cough			
Influenza (annual)			
Tetanus (every 10 years)			
COVID -19			

The above individual is free of any diagnosed disorder or communicable disease which is of potential risk to children / families which might interfere with the performance of his/her duties

Physician's Name_____
License number / NPI_____
Date of exam _____
Physician's Signature _____

Physician's Stamp

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Tuberculosis (TB) Screening and Risk Assessment Form
***Required**

Name: _____ Date: _____
Preferred Contact Information: _____

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 been treated with medication for TB or for a positive TB test (e.g., 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)
A. YES, one or more of these is true for me
B. NO, none of these is true for me

_____ _____
Signature of Licensed Health Care Provider **Date**