C.H.T.Services,Inc.

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ANNUAL MEDICAL FORM

(Last)	*(First)*	*(Middle)*	**SEX** F M	**DATE**	**DATE OF BIRTH** ____/____/____
(No.)	*(Street)*	*(City)*	*(State)*		*(Zip)*

TELEPHONE: AC ( ) **JOB TITLE** **LICENSE/CERTIFICATION #**

PAST MEDICAL HISTORY
Please check YES or NO

Yes	No	
☐	☐	Hypertension
☐	☐	Heart Disease
☐	☐	Diabetes
☐	☐	Seizure Disorder
☐	☐	Chronic Lung Disease
☐	☐	Mental Illness
☐	☐	Alcohol Abuse
☐	☐	Physical Disabilities
☐	☐	Allergies
☐	☐	Hepatitis
☐	☐	Other: _______________

Please explain any positive findings, list explain any chronic medications or therapies: ____________________________
____
____
____
____
____
____
____

MEDICAL PROVIDER SECTION

PHYSICAL EXAM: *(Please note any conditions or findings considered abnormal or requiring medical follow-up)*

Height: _____________ Weight: _____________ Blood Pressure: ______/_______

TUBERCULIN TESTING

TUBERCULIN SKIN TEST: PPD MANTOUX (5TU)
OR
BLOOD TEST: QUANTEFERON GOLD

DATE TESTED: ______________________________
DATE INTERPRETED: ________________________
RESULTS: __________________________________

Staff exempt from testing if they had a positive reaction to a PPD/Mantoux test or history of TB.

DATE: ________________________________

History of BCG vaccine does not exempt staff from TB screening.

DATE: ________________________________

CHEST X-RAY: __________ DONE AT: ____________

DATE: _________________ RESULTS: ______________

TREATMENT: _____________________________
____

IMMUNIZATION RECORD
Staff are required to have evidence of immunity to the diseases below through either documented immunizations, blood test documenting immunity, or provider-documented history of illness (except where shaded in grey). Records should be kept in the personnel file.

Documentation of Immunity	Vaccine Date 1	Vaccine Date 2	OR	Blood Test Documenting Immunity (Yes / No)	Provider-Documented History of Illness (Yes / No)
Tetanus/Diphtheria/ acellular pertussis					
Rubella					
Measles*					
Mumps*					
Varicella*					

*Two doses of vaccine are required at least 28 days apart

RECOMMENDED IMMUNIZATIONS/TITERS

Hepatitis B (Indicate dates of all three vaccines)	Date:	Date:	Date:
Influenza (within the las 12 months)	Date:		

LABORATORY TESTS *(Optional) (Specify tests ordered)*	**DATE**	**RESULTS**

DIAGNOSIS/PROBLEM	**PLAN/FOLLOW-UP** *(For each diagnosis)*
1.	**1.**
2.	**2.**
3.	**3.**
4.	**4.**
5.	**5.**

On the basis of my findings as indicated above and my knowledge of the staff member, I find that the above person is fit to provide service to children in home or center-based setting for Applied Behavioral Interventions.

Provider's Name *(Print):* ___________________________ License No.: _________________________Telephone No.: ____________________

(Of Supervisor if NP or PA)

Address:____Date of Exam ____

Provider's Signature: ______________________________________ Staff Signature: ____

NOTE: Staff Health Records are confidential and must be kept separate from all other records. Records of required medical examinations must be kept on file at C.H,T,Services, Inc. as long as staff members are employed.

(New York City Health Code Section 45.09)