Print Form

PROGRESSIVE INSTITUTE

HEALTH SCREENING REPORT – FACILITY PERSONNEL

A health screening, by or under the direction of a physician must have been performed not more than six (6) months prior to employment or within seven (7) days of employment

APPLICANT INFORMATION	
Person's Name:	Age:
Position Title:	Type of Facility: **Outpatient Treatment Facility**
Work Days Per Week:	Work Hours Per Day:
Duty Statement: Provides direct care services for adolescent and adult outpatient clients.	

TYPES OF PERSONS SERVED (check appropriate items)

- ☐ Infants
- ☒ Adults
- ☐ Developmentally Disabled
- ☐ Physically Handicapped
- ☒ Children
- ☐ Elderly
- ☒ Mentally Disordered
- ☒ Drug/Alcohol Addiction
- ☐ Other (Specify) _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION	
I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION CONTAINED IN THIS REPORT	
Signature of Applicant/ Licensee or Employee:	Date:
Address:	

NOTE TO CLINICIAN: ***Personnel in Outpatient Care Facilities shall be free from communicable disease and capable of performing assigned tasks. Please complete the following information on the above named person.***

EVALUATION OF GENERAL HEALTH

EVALUATION OF ABILITY TO PERFORM WORK DESCRIBED IN THE ABOVE DUTY STATEMENT

NOTE ANY HEALTH CONDITION THAT WOULD CREATE A HAZARD TO THE PERSON, CLIENTS, CHILDREN OR OTHER PERSONNEL

T.B. TEST		
Date T.B. Test Administered:	Date T.B. Test Read:	☐ Positive ☐ Negative
Action Taken (if positive)		

HEALTH SCREENING COMPLETED	
Signature:	Date:
Name of Physician (Physician's Stamp)	Phone:

Declination of Influenza Vaccination

My employer or affiliated health facility, _____, has recommended that I receive influenza vaccination to protect the patients I serve.

I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands of people in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare workers to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, even if my symptoms are mild or non-existent, I can spread it to others and they can become seriously ill.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't change, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including
  - all patients in this healthcare facility
  - my coworkers
  - my family
  - my community

Despite these facts, I am choosing to decline influenza vaccination right now for the following reasons: _____

_____

_____

I understand that I can change my mind at any time and accept influenza vaccination, if vaccine is still available.

I have read and fully understand the information on this declination form.

Signature: _____ Date: _____

Name (print): _____

Department: _____

Reference: CDC. Prevention and Control of Influenza with Vaccines—Recommendations of ACIP at www.cdc.gov/vaccines/hcp/acip-recs/vacc-specific/flu.html

Technical content reviewed by the Centers for Disease Control and Prevention

Immunization Action Coalition Saint Paul, Minnesota ▪ 651-647-9009 ▪ www.immunize.org ▪ www.vaccineinformation.org

www.immunize.org/catg.d/p4068.pdf ▪ Item #P4068 (8/14)