Northwest Community Action – Head Start/Early Head Start
312 North Main Street/PO Box 67
Badger, MN 56714
(218) 528-3226/ (800) 568-5319

PERSONNEL MEDICAL REPORT

Office Use Only

Physical date on file: ____________

Physical due date: ____________

Name of Employee: ____

Job Title: ____

TO THE EMPLOYEE:

New employees are required to provide to Head Start, evidence of a medical examination and TB Screening (skin test) completed within the previous year from employee's start date. If that is unavailable, new employees are required to complete a medical examination and TB Screening (skin test) within 60 days from employee's start date, then a medical examination every 2 years thereafter. A Personnel Medical Report Form will be completed and signed by an examining medical professional. That form will be kept in each individual's personnel file and tracked by the Health Services Manager.

EMPLOYEE PRIVACY RIGHTS:

We are required to protect the privacy of the health information that we collect and keep about you. The information collected will only be shared with yourself, your medical facility, and the Health Services Manager. Under any circumstance other than what's listed above, we will ask for your written authorization before we use or give out any medical information about you. This information is collected for the sole purpose of determining your physical fitness and/or apparent evidence of communicable disease in working with children and families.

TO THE EXAMINING PHYSICIAN:

The above named person has been examined by me in order to determine physical fitness and/or apparent evidence of communicable disease. In my opinion, this person **(check one): is _____; is not _____** physically and emotionally capable of working with children and/or individuals with disabilities.

Tuberculin Test: _____ Required _____ Not Required

NAME	DATE	TYPE	RESULTS
Tuberculin (Skin Test)			
X-Ray (if skin test is positive)			

______________________________, **M.D.**
Licensed Physician's Signature

____
Examination Date

____
Medical Facility

____
Telephone Number

____
Address **City** **State** **Zip**

Baseline TB Screening Tool for Patients

____
Last name, first name, middle initial

____/____/_____
Date of birth

____/____/_____
Date form completed

Baseline TB screening includes three components:
(1) Assessing for current symptoms of active TB disease
and
(2) Assessing the patient's risk factors
and
(3) Testing for the presence of infection with *Mycobacterium tuberculosis* by administering either a single TB blood test *or* a two-step TST.

Patient's history and risk factors (circle response)

				Comments
Ever had an adverse reaction to at TB skin test?	Yes	No	Unknown	
Born outside of the US?	Yes	No	Unknown	
Lived in the US < 5 years?	Yes	No	Unknown	
Traveled or lived outside of the US in the past 2 years?	Yes	No	Unknown	
Ever had a positive reaction to a TB skin test?	Yes	No	Unknown	
Ever had a TB blood test?	Yes	No	Unknown	
Ever had the BCG vaccine?	Yes	No	Unknown	
Ever been treated for latent TB infection?	Yes	No	Unknown	
Ever been treated for active TB disease?	Yes	No	Unknown	
HIV-infected?	Yes	No	Unknown	
Have end stage renal disease, diabetes, or silicosis?	Yes	No	Unknown	
Was the patient infected with TB < 2 years ago?	Yes	No	Unknown	
Undernourished or underweight (< 90% of ideal)	Yes	No	Unknown	
Immune suppressed?	Yes	No	Unknown	
History of substance abuse?	Yes	No	Unknown	
Scarring/fibrosis on chest x-ray?	Yes	No	Unknown	

Symptoms of active TB disease (circle all that are present)

Coughing (>3 weeks)	Chest pain	Fatigue
Night sweats	Coughing up blood	
Weight loss/poor appetite	Fever/chills	

Note: If TB symptoms are present, promptly refer patient for a chest x-ray and full medical examination. Do not wait for the TST result.

TB screening date:________________________