ACTIVE STAFFING RESOURCE INC.
17315 Studebaker Road, Suite 110, Cerritos, CA 90703
Tel. No. (562) 865-3222 | Fax No. (562) 865-5142
asristaffing@yahoo.com

HEALTH CERTIFICATE

*** All information must be completed by a Physician.**

Name: _____ Date: _____

PART I. PHYSICAL EXAMINATION

	REMARKS:
Head/Neck	
EENT	
Respiratory	
Cardiovascular	
Abdomen/GI	
Muscoloskeletal	
Neurological	
Endocrine	
Integumentary	

Blood Pressure	Temperature	Pulse	Height	Weight

Vision: Distant: OD:____ OS:____ OU:____ Near: OD:____ OS:____ OU:____ □Corrected □Uncorrected

Color Vision: □Normal □Abnormal Peripheral Vision: □Normal □Abnormal Depth Perception: □Normal □Abnormal

I have examined the above individual and verify that he/she is free from signs or symptoms of infectious disease. This person is physically and mentally free from health conditions which would interfere with the individual's ability to perform assigned duties.

_____ There are no limitations that would keep this individual from performing his/her job.

_____ Limitations: _____

PRINT Physician Name: _____ License # _____

Signature: _____ Date: _____

Address: _____ Telephone no. _____

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Name: _____ Date: _____

PART II. IMMUNIZATION RECORD

	DATE	RESULTS
TB Skin Test/ CXR (for + PPD)		☐ Positive ☐ Negative
Measles, Mumps, Rubella (MMR) – proof of vaccines or Titer		☐ Immune ☐ Non-immune
Varicella		☐ Immune ☐ Non- immune
Tetanus vaccine		
Hepatitis B Declination		
Hepatits B Titer		
Hepatitis B Vaccine – 1		
Hepatits B Vaccine – 2		
Hepatitis B Vaccine – 3		

PRINT Physician Name: _____ **License #** _____

Signature: _____ **Date:** _____

Address: _____ **Telephone no.** _____

ACTIVE STAFFING RESOURCE INC.

DECLINATION FORM FOR SEASONAL INFLUENZA VACCINE

Name (printed):_____ Last 4 of SSN: _____

Facility: _____ Department: _____

This facility has recommended that I receive influenza vaccination in order to protect myself and the patients I serve.

I DO NOT WANT A FLU SHOT. I acknowledge that I am aware of the following facts:

- ☐ Influenza is a serious respiratory disease; on average, 36,000 Americans die every year from influenza-related causes.
- ☐ Influenza virus may be shed for up to 24 hours before symptoms begin, increasing the risk of transmission to others.
- ☐ Some people with influenza have no symptoms, increasing the risk of transmission to others.
- ☐ Influenza virus changes often, making annual vaccination necessary. Immunity following vaccination is strongest for 2 to 6 months. [In California, influenza usually begins circulating in early January and continues through February or March.]
- ☐ I understand that the influenza vaccine cannot transmit influenza and it does not prevent all disease.
- ☐ I have declined to receive the influenza vaccine for the _____ season.

I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention for all healthcare workers in order to prevent infection from and transmission of influenza and its complications, including death, to patients, my coworkers, my family, and my community. Knowing these facts, I choose to decline vaccination at this time. I may change my mind and accept vaccination later, if vaccine is available. I have read and fully understand the information on this declination for I am declining due to the following reasons (check all that apply):

- ☐ I believe I will get influenza if I get the vaccine.
- ☐ I do not like needles.
- ☐ My philosophical or religious beliefs prohibit vaccination.
- ☐ I have an allergy or medical contraindication to receiving the vaccine.
- ☐ Other reason – please tell us. _____.

I understand that if I choose to decline the influenza vaccine, and my job duties may cause me to infect patients or to become infected, I will be required to wear a surgical mask or respirator, as appropriate, within 6 feet of patients or in designated areas during influenza season. I understand that I may change my mind at any time and accept influenza vaccination, if vaccine is available. I have read and fully understand the information on this declination form.

_____ _____

Signature Date

ACTIVE STAFFING RESOURCE INC.

HEPATITIS B VACCINATION WAIVER

I understand that due to my occupational exposure to blood and other potentially infectious materials I may be at risk of acquiring Hepatitis B virus (HBV) infection.
However, I decline Hepatitis B vaccination at this time. I understand that my declining this option, I continue to be at risk of acquiring Hepatitis B, a serious disease.

I decline this option:

_____ I have already been vaccinated against the Hepatitis B virus.

I was vaccinated at _____ Date _____
(TEST RESULTS WILL NEED TO BE SUBMITTED)

_____ I do not wish to be vaccinated.

I understand I may rescind this waiver at any time during my employment.

Name & Signature: _____ Date: _____

CHICKEN POX

1. Have you ever had Chicken Pox? [ ] Yes [ ] No

   If yes, how old were you? _____ Years old

   What were your symptoms? _____

   _____

   _____

   _____

2. For those with <u>unknown history</u> of chicken pox, a varicella titer is necessary. Persons with negative titers will be restricted from care of patients from day 10 through day 21 after exposure.

Name & Signature: _____ Date: _____

ACTIVE STAFFING RESOURCE INC.

HEPATITIS C DECLINATION FORM

I understand that due to my occupational exposure to patients, blood or other potentially infectious materials, I may be at risk of acquiring an infection. However, I choose to decline to be tested at this time. I understand that by declining this test, I may be exposed to Hepatitis C, and hold Active Staffing resource harmless of any occupational exposure risk, since my status is not currently verified.

Check box that applies:

[ ] I refuse testing at this time for personal reason.
[ ] I had been last tested _____

Name: _____ Signature: _____

Date: _____

ACTIVE STAFFING RESOURCE INC.

LATEX ALLERGY QUESTIONNAIRE

Check box that applies:

[ ] I do not have a latex allergy.
[ ] I do have a latex allergy

Name: _____ Signature: _____

Date: _____

ACTIVE STAFFING RESOURCE INC.

TB QUESTIONNAIRE

Please answer all questions:

	YES	NO
1. Do you have a persistent cough? ……	□	□
2. Do you cough up sputum frequently – sometimes daily? …….	□	□
3. Have you lost more than 10 lbs. w/o dieting in the last 6 months? …….	□	□
4. Has your appetite decreased dramatically in the past 6 months? ……	□	□
5. Do you have night sweats? ……..	□	□
6. Do you have fevers and chills? ……...	□	□
7. Has any member of your family developed any of the symptoms above?	□	□
8. Has a family member had tuberculosis? If yes, explain _____	□	□
_____	□	□
9. Have you ever been tested for TB? If yes, please list date_____	□	□
If tested were you negative or positive?	□	□
If positive did you have a chest X-Ray? If yes, when? _____	□	□
10. Have you ever been treated for tuberculosis? If yes, explain. _____	□	□
11. Are you taking any medication? If yes, explain _____	□	□
_____		

Employee Name: _____

Employee Signature: _____ Date: _____

ACTIVE STAFFING RESOURCE INC.

TDAP IMMUNIZATION DECLINATION FORM

I understand that due to my occupational exposure to patients, blood or other potentially infectious materials, I may be at risk of acquiring an infection. However, I choose to decline the vaccination at this time. I understand that by declining this vaccine I continue to be at risk of acquiring an infection.

Check box that applies:

[ ] I refuse vaccination at this time for personal reason.

[ ] I had the vaccination last _____

Name: _____ Signature: _____

Date: _____