Step (New hire) **CENTRA EMPLOYEE HEALTH** Required Update_____
#1_____ Phone: 434-200-3082 Exposure_____
#2_____ Fax: 434-200-5842

SELF READING IS NOT ACCEPTABLE

PLEASE REMEMBER TO RETURN THIS FORM TO EMPLOYEE HEALTH TO MEET THE MANDATORY REQUIREMENT

NAME:_____ EMPLOYEE #/DOB_____

DEPARTMENT:_____

Have any medical conditions that may impact your ability to perform your job function developed since last employee screening? Yes_____ No_____
If yes, describe:_____

Are you experiencing any of the following symptoms?
___Loss of appetite ___Pain in Chest ___Fever (generally at night) ___Productive cough
___Unexplained Weight Loss ___Night Sweats ___ Fatigue ___Hemoptysis

Please answer the following questions:

Do you have a fever at the present time?	_____ Yes	_____ No
Are you pregnant? (Women only)	_____ Yes	_____ No
Has BCG (TB vaccine) ever been administered to you?	_____ Yes	_____ No
Are you taking steroids or cancer drugs?	_____ Yes	_____ No
Have you had a viral infection within 8 weeks due to Influenza, Mumps, Measles, etc	_____ Yes	_____ No
Have you had a live virus vaccination within the last 8 weeks (Measles, Mumps, Polio, Influenza Mist, Yellow Fever, Small Pox)	_____ Yes	_____ No
Have you ever had a positive reaction to a Tuberculin Skin Test?	_____ Yes	_____ No

I have answered the above questions to the best of my knowledge. I understand that the above questions will only be used to determine if a TST can be administered. I consent to TST administration if not contraindicated due to past positive reaction.

_____ _____
Signature Date

Date/Time Given:_____Site:_____ Date/Time Read:_____

Manufacturer:_____ Result:_____MM

Lot #:_____ Exp. Date:_____ Signature of Reader_____

Administered by:_____

READ AFTER _____/_____ AND BEFORE_____/_____.
DATE TIME DATE TIME

MAY BE READ BY ANY RN/LPN IF NO REACTION
FOR ANY SITE REDNESS OR INDURATION REPORT IMMEDIATELY TO EMPLOYEE HEALTH
Care of site: 1. Blot gently. 2. No lotion/cream to area. 3. No scrubbing or scratching.
4. OK to shower/swim.
Revised 9/08