RWJBarnabas HEALTH- Corporate Care / Employee Health

3-31-17 Attachment #1: **Consent and Authorization to Treat Form.**

Name (Please Print):
_____Birthdate:_____

I hereby give my consent for diagnostic testing and a physical examination to evaluate my suitability for employment within RWJBarnabas HEALTH. I understand that this exam and subsequent exams are to determine my placement and continued work status and not intended to take the place of personal medical care. Additionally, these exams should not be considered complete health assessments; for that I must contact my personal physician.

I further consent to diagnostic procedures and/or treatment for any injury or illness that occurs in relationship to my employment, or for any other conditions for which I seek care in the Employee Health Department.

I understand that my medical records will be maintained in a confidential manner. If I transfer to an alternate site within RWJBarnabas HEALTH, I agree that my employee medical records may be transferred to the Employee/Occupational Health Department responsible for the site at which I am working. Medical records pertaining to a work-related occurrence may be made available to the workers' compensation insurance carrier.

My responses to the employee Medical History Record Questionnaire will be used to evaluate suitability for employment and/or whether a reasonable accommodation for any disability will be needed.

I understand that it is important to provide all medical information to the best of my knowledge. If there is information I am uncertain of in this application to this request, I must discuss it with a representative from Employee Health Services. Omitting information or providing false information on the medical history form is grounds for withdrawal of an employment offer or termination of employment.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information.

"Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

_____ _____
Employee Signature Date

_____ _____
Witness Signature Date

( ) I have received and read this Consent and Authorization to Treat Form and do NOT provide consent for diagnostic testing and a physical examination.

_____ _____
Employee Signature Date

RWJBarnabas HEATH- Corporate Care / Employee Health

1-17-17 Attachment #2: **Conditions of Employment Form**

Employee Name: _____ **D.O.B**.: _____
In order to protect your health and that of RWJBarnabas HEALTH patients, medical clearance to work is contingent upon:

1. Successful completion of a physical examination performed or approved by the Corporate Care / Employee Health Department.

2. A negative drug screen.

3. Pre-placement testing including laboratory work, a 2-step Mantoux (PPD) tuberculin test (or other documentation), and other diagnostic studies, as indicated.

4. Demonstration of Measles, Mumps, Rubella, and Varicella immunity by quantitative antibody titer level. Employees that are susceptible will be vaccinated (unless contraindicated) at no cost. Proof of immunity may require one or more vaccinations.

5. Demonstration of Hepatitis B immunity by a 'positive' antibody titer level. New employees that are susceptible will be vaccinated (unless contraindicated) at no cost. The hepatitis B vaccine series requires 3 immunizations given over 6 months. A follow-up blood test, to ensure immunity, is drawn 1 to 2 months after the last immunization. Note: if a new employee declines the hepatitis B vaccines, they are required to sign the OSHA Hepatitis B Vaccine Declination Statement.

6. Demonstration of a Td**ap** (Tetanus, diphtheria, **pertussis**) vaccination given as an adult. Employees that do not have medical documentation of a Td**ap** vaccination (as an adult) will be vaccinated (unless contraindicated) at no cost.

7. Influenza vaccination during the influenza season (usually September 1st - March 31st).

8. Tuberculosis screening at intervals determined by my facility based on a risk assessment.

9. Other follow-up as clinically indicated.

10. I understand that if I have a work-related occurrence my medical records may be made available to the worker's compensation insurance carrier.

11. I understand that information regarding my physical condition may be revealed to supervisors on a need-to-know basis if a potential for harm to myself or others exists.

I have read the above and I have had an opportunity to ask any questions which I may have. I understand that failure to comply with this policy will prevent my being employed and/or result in my termination from RWJBarnabas HEALTH.

Employee Signature: _____ Date: _____

RWJBarnabas HEALTH- Corporate Care / Employee Health

1-17-17 Attachment #3: **Employment Medical History Form** **PATIENT HISTORY RECORD**

Name:_____ Date of Birth: _____ SS#: _____

Full Address:_____ Home Phone # ( ) _____

Email Address: _____CELL Phone # ( ) _____

In case of emergency notify (Name):_____Relationship:_____

Full Address:_____ Phone # ( ) _____

Allergies:_____

Do you now have or have you ever had any of the following? Check YES or NO. If yes, give year of occurrence.

	YES	NO	YEAR		YES	NO	YEAR		YES	NO	YEAR
Recurrent cough				Rectal bleeding				Back trouble			
Coughing up blood				Jaundice (yellow skin)				Arthritis			
Shortness of breath				Leg pains				Joint pains			
Emphysema				Ankle swelling				Broken bones			
Asthma				Hernia				Osteoporosis			
Abnormal chest x-ray				Urine problem				Ear trouble, deafness			
Tuberculosis history				Cancer or tumor				Eye/vision trouble			
Dizzy spells				Blood transfusion				Nose trouble			
Chest pain / Angina				Anemia/blood disorder				Throat trouble			
Irregular heart beat				Unplanned weight loss				Kidney/bladder problem			
Heart trouble/Heart attack				Diabetes				Eczema/hives/skin probl			
High blood pressure				Seizures, Convulsions, fits				Black stool			
Fainting spells				Headaches				Testicular/prostate trouble			
Frequent indigestion				Paralysis				Breast lump/discharge			
Vomiting of blood				Numbness, tingling				Stoke or TIA			
Hepatitis A				Emotional/mental illness				Any Brain/Neurologic illness			
Hepatitis B				Drug/alcohol problem				Past MRI tests			
Hepatitis C				Latex/chemical sensitivity				Other			
Gallbladder trouble				Wheezing				Other			

List any significant health issues not mentioned above:_____

	YES	NO	Amount Consumed
Alcohol			
Tobacco			
Former smoker?			
Prescription drugs			
Non-prescription drugs			

Previous occupation(s):_____

Previous work-related injury/illness? Yes_____ No_____

Type:_____

Have you ever been rejected for employment, military service or insurance for health reasons? Yes_____ No_____

Why?_____

List ALL present medications:

_____

_____

_____

_____

_____

Have you ever received workers' compensation benefits?

Yes_____ No_____ Describe:_____

Do you require accommodation/special assistance of any kind?

Yes_____ No_____ Describe:_____

Do you use any aids or assistive devices (prosthesis)?

Yes_____ No_____ Describe:_____

List injuries, illnesses, Surgeries, or Hospitalizations	Date

I certify that the answers to the above questions are true, correct and complete. I understand that any false, incomplete or misleading information may be considered sufficient grounds for immediate rejection or termination when discovered.

_____ _____

Signature of applicant or guardian **Date**

Attachment # 4: **OSHA Respirator Questionnaire Form**

- Appendix C to Sec. 1910.134: OSHA Respirator Medical Evaluation Questionnaire-Mandatory.
- Use for Medical Clearance for: N-95 Disposable, PAPR, and half-face negative pressure.

Please answer ALL of the questions on the following pages.

To the employee: Can you read (circle one): Yes/No
Your employer must allow you to answer this questionnaire during normal working hours, or at a time and place that is convenient to you. To maintain your confidentiality, your employer or supervisor must not look at or review your answers, and your employer must tell you how to deliver or send this questionnaire to the health care professional who will review it.

Part A. Section 1. (Mandatory) The following information must be provided by every employee who has been selected to use any type of respirator (please print).

1. Today's date:_____
2. Your name:_____
3. Your age (to nearest year):_____
4. Sex (circle one): Male / Female
5. Your height: _____ ft. _____ in.
6. Your weight: _____ lbs.
7. Your job title:_____
8. A phone number where you can be reached by the health care professional who reviews this questionnaire (include the Area Code): _____
9. The best time to phone you at this number: _____
10. Has your employer told you how to contact the health care professional who will review this questionnaire (circle one): Yes/No

11. Check the type of respirator you will use (you can check more than one category):
    a. _____ N, R, or P disposable respirator (filter-mask, non-cartridge type only).
    b. _____ Other type (for example, half- or full-facepiece type, powered-air purifying, supplied-air, self-contained breathing apparatus).
12. Have you worn a respirator (circle one): Yes/No. If "yes," what type(s):_____

Pa**rt A. Section 2. (Mandatory**) Questions 1 through 9 below must be answered by every employee who has been selected to use any type of respirator (please circle "yes" or "no").

1. Do you ***currently*** smoke tobacco, or have you smoked tobacco in the last month: Yes/No

2. Have you ***ever had*** any of the following conditions?
    a. Seizures (fits): Yes/No
    b. Diabetes (sugar disease): Yes/No
    c. Allergic reactions that interfere with your breathing: Yes/No
    d. Claustrophobia (fear of closed-in places): Yes/No
    e. Trouble smelling odors: Yes/No

3. Have you ***ever had*** any of the following pulmonary or lung problems?
    a. Asbestosis: Yes/No
    b. Asthma: Yes/No
    c. Chronic bronchitis: Yes/No
    d. Emphysema: Yes/No
    e. Pneumonia: Yes/No
    f. Tuberculosis: Yes/No
    g. Silicosis: Yes/No
    h. Pneumothorax (collapsed lung): Yes/No
    i. Lung cancer: Yes/No
    j. Broken ribs: Yes/No
    k. Any chest injuries or surgeries: Yes/No
    l. Any other lung problem that you've been told about: Yes/No

4. Do you ***currently*** have any of the following symptoms of pulmonary or lung illness?
    a. Shortness of breath: Yes/No
    b. Shortness of breath when walking fast on level ground or walking up a slight hill or incline: Yes/No
    c. Shortness of breath when walking with other people at an ordinary pace on level ground: Yes/No
    d. Have to stop for breath when walking at your own pace on level ground: Yes/No
    e. Shortness of breath when washing or dressing yourself: Yes/No
    f. Shortness of breath that interferes with your job: Yes/No
    g. Coughing that produces phlegm (thick sputum): Yes/No
    h. Coughing that wakes you early in the morning: Yes/No
    i. Coughing that occurs mostly when you are lying down: Yes/No
    j. Coughing up blood in the last month: Yes/No
    k. Wheezing: Yes/No
    l. Wheezing that interferes with your job: Yes/No
    m. Chest pain when you breathe deeply: Yes/No
    n. Any other symptoms that you think may be related to lung problems: Yes/No

5. Have you ***ever had*** any of the following cardiovascular or heart problems?
    a. Heart attack: Yes/No
    b. Stroke: Yes/No
    c. Angina: Yes/No
    d. Heart failure: Yes/No
    e. Swelling in your legs or feet (not caused by walking): Yes/No
    f. Heart arrhythmia (heart beating irregularly): Yes/No
    g. High blood pressure: Yes/No
    h. Any other heart problem that you've been told about: Yes/No

6. Have you ***ever had*** any of the following cardiovascular or heart symptoms?
    a. Frequent pain or tightness in your chest: Yes/No
    b. Pain or tightness in your chest during physical activity: Yes/No
    c. Pain or tightness in your chest that interferes with your job: Yes/No
    d. In the past two years, have you noticed your heart skipping or missing a beat: Yes/No
    e. Heartburn or indigestion that is not related to eating: Yes/No
    f. Any other symptoms that you think may be related to heart or circulation problems: Yes/No

7. Do you ***currently*** take medication for any of the following problems?
    a. Breathing or lung problems: Yes/No
    b. Heart trouble: Yes/No
    c. Blood pressure: Yes/No
    d. Seizures (fits): Yes/No

8. If you've used a respirator, have you ***ever had*** any of the following problems:
    a. Eye irritation: Yes/No
    b. Skin allergies or rashes: Yes/No
    c. Anxiety: Yes/No
    d. General weakness or fatigue: Yes/No
    e. Any other problem that interferes with your use of a respirator: Yes/No

9. Would you like to talk to the health care professional who will review this questionnaire about your answers to this questionnaire: Yes/No

Employee Signature: _____ Date: _____

RWJBarnabas HEALTH- Corporate Care / Employee Health

1-17-17 Attachment #5 **Latex Allergy Screening Form**

1. Are you allergic to any of the following types of GLOVES?

LATEX Yes / No (If yes, please explain:_____.)

VINYL Yes / No (If yes, please explain:_____.)

NITRILE Yes / No (If yes, please explain:_____.)

If you are allergic to any of the above, do you know the Specific Name of the glove you are allergic to?

_____

2. When wearing Latex, or Vinyl, or Nitrile GLOVES, do you develop any rash, itching, cracking, chapping, scaling, or weeping of the skin on your hands and/or wrists? **Yes / No**

(If Yes, what is the Name and Type of glove? _____.)

Employee Signature: _____ Date: _____

Attachment #6 **Tdap - CDC (Center for Disease Control) Vaccine Information Statement (VIS)**

Tdap (Tetanus, Diphtheria, Pertussis) Vaccine: What You Need to Know

Many Vaccine Information Statements are available in Spanish and other languages. See www.immunize.org/vis.
Hojas de Información Sobre Vacunas están disponibles en español y en muchos otros idiomas. Visite http://www.immunize.org/vis

1. Why get vaccinated?

Tetanus, **diphtheria,** and **pertussis** are very serious diseases. Tdap vaccine can protect us from these diseases. And, Tdap vaccine given to pregnant women can protect newborn babies against pertussis.

TETANUS (Lockjaw) is rare in the United States today. It causes painful muscle tightening and stiffness, usually all over the body.

- It can lead to tightening of muscles in the head and neck so you can't open your mouth, swallow, or sometimes even breathe. Tetanus kills about 1 out of 10 people who are infected even after receiving the best medical care.

DIPHTHERIA is also rare in the United States today. It can cause a thick coating to form in the back of the throat.

- It can lead to breathing problems, heart failure, paralysis, and death.

PERTUSSIS (Whooping Cough) causes severe coughing spells, which can cause difficulty breathing, vomiting, and disturbed sleep.

- It can also lead to weight loss, incontinence, and rib fractures. Up to 2 in 100 adolescents and 5 in 100 adults with pertussis are hospitalized or have complications, which could include pneumonia or death.

These diseases are caused by bacteria. Diphtheria and pertussis are spread from person to person through secretions from coughing or sneezing. Tetanus enters the body through cuts, scratches, or wounds.

Before vaccines, as many as 200,000 cases of diphtheria, 200,000 cases of pertussis, and hundreds of cases of tetanus, were reported in the United States each year. Since vaccination began, reports of cases for tetanus and diphtheria have dropped by about 99% and for pertussis by about 80%.

2. Tdap vaccine

- Tdap vaccine can protect adolescents and adults from tetanus, diphtheria, and pertussis. One dose of Tdap is routinely given at age 11 or 12. People who did *not* get Tdap at that age should get it as soon as possible.
- Tdap is especially important for health care professionals and anyone having close contact with a baby younger than 12 months.
- Pregnant women should get a dose of Tdap during **every pregnancy**, to protect the newborn from pertussis. Infants are most at risk for severe, life-threatening complications from pertussis.
- Another vaccine, called Td, protects against tetanus and diphtheria, but not pertussis. A Td booster should be given every 10 years. Tdap may be given as one of these boosters if you have never gotten Tdap before. Tdap may also be given after a severe cut or burn to prevent tetanus infection.
- Your doctor or the person giving you the vaccine can give you more information.

Tdap may safely be given at the same time as other vaccines.

3. Some people should not get this vaccine

- A person who has ever had a life-threatening allergic reaction after a previous dose of any diphtheria, tetanus or pertussis containing vaccine, OR has a severe allergy to any part of this vaccine, should not get Tdap vaccine. *Tell the person giving the vaccine about any severe allergies.*
- Anyone who had coma or long repeated seizures within 7 days after a childhood dose of DTP or DTaP, or a previous dose of Tdap, should not get Tdap, unless a cause other than the vaccine was found. They can still get Td.
- Talk to your doctor if you:
  - have seizures or another nervous system problem,
  - had *severe* pain or swelling after any vaccine containing diphtheria, tetanus or pertussis,
  - ever had a condition called Guillain Barré Syndrome (GBS),
  - aren't feeling well on the day the shot is scheduled.

4. Risks

With any medicine, including vaccines, there is a chance of side effects. These are usually mild and go away on their own. Serious reactions are also possible but are rare. Most people who get Tdap vaccine do not have any problems with it.

Mild Problems following Tdap *(Did not interfere with activities)*

- Pain where the shot was given (about 3 in 4 adolescents or 2 in 3 adults)
- Redness or swelling where the shot was given (about 1 person in 5)
- Mild fever of at least 100.4°F (up to about 1 in 25 adolescents or 1 in 100 adults)
- Headache (about 3 or 4 people in 10)
- Tiredness (about 1 person in 3 or 4)
- Nausea, vomiting, diarrhea, stomach ache (up to 1 in 4 adolescents or 1 in 10 adults)
- Chills, sore joints (about 1 person in 10)
- Body aches (about 1 person in 3 or 4)

- Rash, swollen glands (uncommon)

Moderate Problems following Tdap *(Interfered with activities, but did not require medical attention)*
- Pain where the shot was given (up to 1 in 5 or 6)
- Redness or swelling where the shot was given (up to about 1 in 16 adolescents or 1 in 12 adults)
- Fever over 102°F (about 1 in 100 adolescents or 1 in 250 adults)
- Headache (about 1 in 7 adolescents or 1 in 10 adults)
- Nausea, vomiting, diarrhea, stomach ache (up to 1 or 3 people in 100)
- Swelling of the entire arm where the shot was given (up to about 1 in 500).

Severe Problems following Tdap *(Unable to perform usual activities; required medical attention)*
- Swelling, severe pain, bleeding, and redness in the arm where the shot was given (rare).

Problems that could happen after any vaccine:
- People sometimes faint after a medical procedure, including vaccination. Sitting or lying down for about 15 minutes can help prevent fainting, and injuries caused by a fall. Tell your doctor if you feel dizzy, or have vision changes or ringing in the ears.
- Some people get severe pain in the shoulder and have difficulty moving the arm where a shot was given. This happens very rarely.
- Any medication can cause a severe allergic reaction. Such reactions from a vaccine are very rare, estimated at fewer than 1 in a million doses, and would happen within a few minutes to a few hours after the vaccination.

As with any medicine, there is a very remote chance of a vaccine causing a serious injury or death.
The safety of vaccines is always being monitored. For more information, visit: **www.cdc.gov/vaccinesafety/**

5. What if there is a serious problem?
What should I look for?
- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or unusual behavior.
- Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would usually start a few minutes to a few hours after the vaccination.

What should I do?
- If you think it is a severe allergic reaction or other emergency that can't wait, call 9-1-1 or get the person to the nearest hospital. Otherwise, call your doctor.
- Afterward, the reaction should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your doctor might file this report, or you can do it yourself through the VAERS web site at **www.vaers.hhs.gov**, or by calling **1-800-822-7967**. *VAERS does not give medical advice*.

6. The National Vaccine Injury Compensation Program
The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines.
Persons who believe they may have been injured by a vaccine can learn about the program and about filing a claim by calling **1-800-338-2382** or visiting the VICP website at www.hrsa.gov/vaccinecompensation. There is a time limit to file a claim for compensation.

7. How can I learn more?
- Ask your doctor. He or she can give you the vaccine package insert or suggest other sources of information.
- Call your local or state health department.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at www.cdc.gov/vaccines

RWJBarnabas HEALTH- Corporate Care / Employee Health

1-17-17 Attachment #7 **Tdap** (Tetanus, diphtheria, acellular pertussis) **Vaccine Consent Form**

Patient Name (PRINT) _____ Birthdate _____

Tetanus, diphtheria and pertussis are very serious diseases. Tdap vaccine can protect us from these diseases. And, Tdap vaccine given to pregnant women can protect newborn babies against pertussis. Tdap vaccine is given once during each pregnancy, ideally between 27 and 36 weeks gestation (but it can be given anytime during pregnancy if it is medically indicated- for wound care or during a community pertussis outbreak).

TETANUS (Lockjaw) causes painful muscle tightening and stiffness, usually all over the body.
DIPHTHERIA can cause a thick coating to form in the back of the throat and can lead to breathing problems, heart failure, paralysis, and death.
PERTUSSIS (Whooping Cough) causes severe coughing spells, which can cause difficulty breathing, vomiting and disturbed sleep. It can also lead to weight loss, incontinence, and rib fractures. Up to 2 in 100 adolescents and 5 in 100 adults with pertussis are hospitalized or have complications, which could include pneumonia or death. It is spread from person to person through secretions from coughing or sneezing.

The Center for Disease Control (CDC) recommends that all healthcare personnel receive one (1) dose of the Tdap vaccine regardless of the time since their most recent Td vaccination.
The Tdap adult vaccine became available in 2005; common names for it are Adacel ® and Boostrix ®.

PLEASE ANSWER THE FOLLOWING QUESTIONS (circle your response):

1. Have you ever had a life-threatening allergic reaction after a previous dose of any diphtheria, tetanus or pertussis containing vaccine (they are routine childhood vaccines with last dose given at age 11 or 12)? Yes No

2. Have you ever had coma or long repeated seizures within 7 days after a childhood dose of DTP or DTaP, or a previous dose of Tdap? Yes No

3. Do you currently have seizures or another nervous system problem? Yes No

4. Do you have a history of severe pain or swelling after any vaccine containing diphtheria, tetanus or pertussis? Yes No

5. Have you ever had a condition called Guillain-Barre Syndrome (GBS)? Yes No
6. Do you feel ill today? Yes No

I have been given and have read the most recent version of the Center for Disease Control (CDC) Vaccine Information Sheet (VIS) for Tdap; and have had the opportunity to ask questions.

Patient/Employee Signature _____ Date _____

For BARNABAS HEALTH - Corporate Care / Employee Health Clinic MEDICAL STAFF only:
Tdap Manufacturer:_____ Lot #:_____ Expir.Date: _____ Dose: _____ (ml)
Time given: _____ Date given: _____ Site: LEFT or RIGHT - deltoid
Healthcare Professional Signature: _____

RWJBarnabas HEALTH- Corporate Care / Employee Health

3-31-17 Attachment #8 **Physical Examination Form** Today Date: _____

Name: _____ Sex: _____ Date of Birth: _____
(First)
(Last)

Height: _____ Weight: _____ B/P: _____ Temp: _____ Pulse: _____ Respiration: _____

	Right Eye	Left Eye	Both	**Color Perception (Pass/Fail):**
Far Vision:With**OUT** Correct Lens:	_____	_____	_____	**Ishihara: _____**
WITH Correct Lens:	_____	_____	_____	**Red-Green-Yellow: _____**

Clinical Evaluation

Normal	Abnormal	Check each item, "NE" if not evaluated	Comments/Findings
		Eyes	
		Nose	
		Ears	
		Mouth/Throat	
		Head/Neck	
		Thyroid	
		Chest/Lungs	
		Heart	
		Vascular System	
		Abdomen	
		Hernia	
		Upper Extremities	
		Lower Extremities	
		Back/Spine	
		Skin	
		Lymph Nodes	
		Neuro	
Remarks:			

Date: _____ Signature of Examiner: _____
(Physician (MD, DO) or Nurse Practitioner (NP) only)