Westchester gov.com

Westchester County Department of Health – Health Information Form

Name: ______________________________DOB: ___________Discipline: _____________License/Certification #:_____________
(Print Name)

REQUIRED

I. Tuberculin Skin Test -Mantoux:

A. Date test administered: __________ Date test read: ___________Results: _______________mm induration

B. If previous test was negative and the last test was positive, indicate if follow-up Chest x-ray was done.

Date:___________ Normal ☐ Abnormal ☐ Follow-up/treatment if indicated: ____________________

II. **Measles, Mumps, Rubella (MMR)** Date of immunization(s):____________ or Date of titer and results:____________

Physical Examination Recommended
(This portion should be completed by your Primary Care Provider)

Health Statement
In compliance with the New York State "Health and Safety Standards for Early Intervention Program" Guidance Document, I have examined the above named individual and found that this individual has no diagnosed disorder that would preclude him/her from providing services and is free from communicable disease.

Primary Care Provider's (stamp):

________________________________ (Name)   ______________________________ (Primary Care Provider Signature)   ____________ (Date)

________________________________ (Address)   _____________________________ (Date of Exam)

RECOMMENDED IMMUNIZATIONS/TITERS

Hepatitis B (Indicate dates of all three vaccines): _________________ (Date) _________________ (Date) ________________ (Date)

Tetanus/Diphtheria/Pertussis (Tdap): _________________ (Date)
Substitute one-time does of Tdap for
Td booster then Td every 10 years

Tetanus within past 10 yrs (Td): _________________ (Date)

Varicella: _________________ (Date)

Influenza: _________________ (Date)

DRUG/ALCOHOL DECLARATION

I am not habituated or addicted to depressants, stimulants, narcotics, alcohol or other substances nor do I have a physical or emotional condition that may alter my behavior, interfere with the performance of my duties or pose a potential risk to patients. The responses above are true to the best of my knowledge. I understand that any omissions, error and/or misstatement of facts may be grounds for termination of my WCDH contract.

Individual Provider's Signature ____ Date: ______________________