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):_____Date of titer/results:_____

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

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 within past 10 yrs (Td): _____
(Date)

Or

Tetanus/Diphtheria/Pertussis (Tdap): _____
(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: _____