New Employment Medical Screening Form

Last:______________________ First:_______________________ MI:_________ Sex (circle one) M/F

Date of Birth:_________________ SAP#:_____________________________ Date Hired:______________________

Work Department_______________________ Job Title____________________ Supervisor: __________________

Home Address: ____

City: _________________________________ State: __________________________ Zip Code__________________

Home Phone:________________________________ Work Phone:_______________________________________

________ (initial) I understand that as a UAMS employee or contract employee I am required to have a seasonal flu shot.

List all allergies:____

Have you ever had Chicken Pox? Yes / No / Unknown

If not, have you taken care of someone with Chicken Pox? Yes/ No

Do you use tobacco products? Yes/ No Type of tobacco product:_____________________

Does your job involve nutritional services? Yes/ No

Does your job involve DLAM (working with research animals)? Yes/No

Does your job involve exposure to isolates of Neisseria *meningitides*? Yes/No

Does your job require contact or potential contact with blood or body fluids? Yes/ No

*****THE FOLLOWING TO BE COMPLETED BY THE SEHS NURSE *****

Blood Pressure _____/_____

Country you were born in? _____________________ Have you received the BCG? Yes/No

Color Vision Screenings are indicated for all testable positions:

(**Clinical lab tech., MA, CCT, NURSES, PHYSICIANS/RESIDENTS)** Passed/ Failed

Allergy screening questionnaire completed (DLAM only): Yes/No

Have you ever received the meningococcal vaccine? Yes/No Date Received: ____________ Type: ________

Have you ever received any of the Hepatitis B vaccines? Yes/ No

Dates received: Hep B (1) _________________Hep B (2) ___________________ Hep B (3)______________________

Vaccines Administered and Date:

MMR (1):_____________ MMR (2):________________ TD/TDAP:________________ Hepatitis A:_________________

Lab studies ordered: Rubella titer:___ Varicella titer:___ Rubeola titer:___ Urine Pregnancy Test___

Attach results or forward to SEHS when completed

#1 TST date: _______________ Site:________________ Dose:_________ Nurse:__________________________________

Read Date: _________________ Results (mm):_____ Positive/ Negative Nurse:_______________________________

#2 TST date: _______________ Site:________________ Dose:_________ Nurse:__________________________________

Read Date: _________________ Results (mm):_____ Positive/ Negative Nurse:_______________________________

SEHS USE ONLY: Appointment DATE/ TIME:___________________________________ Main Clinic/ Satellite Clinic

- **ALL EMPLOYEES, STUDENTS AND VOLUNTEERS ARE REQUIRED TO RECEIVE OR SHOW PROOF OF: 2 MMR, 1 TDAP THEN A TD BOOSTER EVERY 10 YEARS, FLU VACCINE YEARLY**
- **ALL NEW EMPLOYEES, REGARDLESS OF POSITION, MUST COMPLETE A NEMS AND TST**