HOSPICE PROVIDERS
OF THE DESERT, INC.

268 N Lincoln Ave Suite 7A Corona, CA 92882
Phone: (951) 808 3060 • (888) 868-0059 Fax: (951) 808-3078
Email: info@hospicePD.com
Website: www.hospicePD.com

INFLUENZA VACCINE ACKNOWLEDGEMENT & WAIVER

☐ I, the undersigned, wish to receive a vaccination against influenza. I am taking this vaccine voluntarily and consent to the vaccination being given to me. I have read the information provided (Influenza VIS). I understand the risks and benefits of this vaccine. I have had an opportunity to ask questions which have been answered to my satisfaction. I hereby waive any claim for damages that I (or anyone claiming on my behalf) may have against HOSPICE PROVIDERS OF THE DESERT, INC., its directors, employees and agents on account of any injury or misfortune I may suffer as a result of this vaccination.

☐ I do not wish to receive vaccination against influenza.

Reason: ☐ Financial ☐ Medical (Allergy) ☐ Convenience (no time) ☐ Others:_____

Employee Name: _____ Signature_____Date: _____

Please answer the following questions. A nurse or physician will review any "yes" answers. Are you allergic to chicken, egg or egg products?	YES	NO
Have you ever had an allergic reaction to a flu shot?	YES	NO
Are you pregnant, or think you may be?	YES	NO
Are you sick today with a fever greater than 100.4?	YES	NO
Have you been sick in the past two weeks?	YES	NO

CLINICAL USE:

Patient Identifier MR#_____ Patient Diagnosis: _____
Vaccine Name _____ Lot # _____ Dose _____
Administration Date _____/_____/_____ Time _____ PM / AM Right Deltoid_____
Left Deltoid_____

Name, signature and title of the Vaccine Administrator:

_____ _____ _____
Name and Title Signature Date

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Hepatitis B Vaccine Acceptance / Declination

ACCEPTANCE

I consent to the administration of hepatitis B vaccine to me by a physician's service approved by HOSPICE PROVIDERS OF THE DESERT, INC. I have read the package insert concerning the vaccine, including the contraindications and precautions. I understand there is no charge to me for receiving this vaccine. I hereby release HOSPICE PROVIDERS OF THE DESERT, INC. from all liabilities associated with the administration of the vaccine.

I accept _____
Signature Date

DECLINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk for acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccination, I continue to be at risk of acquiring hepatitis B, a serious disease. If, in the future, I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

I decline _____
Signature Date

Name: _____
Please Print

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EMPLOYEE HISTORY AND PHYSICAL AND HEALTH EXAMINATION

TO BE FILLED BY EMPLOYEE

Name: _____ DOB: _____ Sex: M ☐ F ☐

History: (explain all Yes answers below)

Y	N		Y	N		Y	N	
☐	☐	Neurological	☐	☐	Vision	☐	☐	Ears/Hearing
☐	☐	Seizures	☐	☐	Heart	☐	☐	High BP
☐	☐	Vascular	☐	☐	Respiratory	☐	☐	Asthma
☐	☐	Back Problems	☐	☐	Skin Disorders	☐	☐	Hay Fever
☐	☐	TB	☐	☐	Bleeding	☐	☐	Arthritis
☐	☐	Kidney/GU Disorders	☐	☐	Gout	☐	☐	GI Disorders
☐	☐	Thyroid	☐	☐	Jaundice/Liver Disorder			
☐	☐	Diabetes	☐	☐	Headaches	☐	☐	Other _____

Comments: _____

Routine medications taken: _____

CLINICAL FINDINGS: TO BE FILLED BY PHYSICIAN

BP: _____ HR: _____RR: _____ TEMP: _____ Back bending: _____Straight leg bending: _____Rising from supine: _____ Extremities: _____

Comments:

_____

_____

TESTS	**DATE PERFORMED**	**RESULTS**
PPD	_____	_____
CXR	_____	_____
OTHER	_____	_____
	_____	_____
HEENT	_____	_____
CARDIAC	_____	_____
PULMONARY	_____	_____
NEURO	_____	_____
G.I.	_____	_____
G.U.	_____	_____
INTEGUMENTARY	_____	_____
ENDOCRINE	_____	_____
PSYCHO-SOCIAL		

Comments and recommendations:

_____

I have examined the above individual and found this a person to be free from communicable diseases and able to perform assigned clinical duties and does not have any health condition that could create hazard for himself/herself/fellow employees/patient(s), or visitor(s).

_____ **MD** _____

Physician Name and Signature **Date**

_____ _____

Address **Telephone #**

_____

City **State** **Zip Code**

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EMPLOYEE TB SYMPTOM SCREENING QUESTIONNAIRE

Employee Name: _____ Date: _____

Job Title: _____ Work Phone: _____

SSN: _____ DOB: _____

1. In the last year, have you had any of the following symptoms?

   ☐ Yes ☐ No Coughing up Blood
   ☐ Yes ☐ No Hoarseness Lasting Three (3) Weeks or More
   ☐ Yes ☐ No Persistent Cough Lasting Three (3) Weeks or More
   ☐ Yes ☐ No Unexplained, Excessive Sweating At Night
   ☐ Yes ☐ No Unexplained Weight Loss

If you checked 'Yes' to any of the above, please answer the following questions:

2. In the last year, have you been told by a health care provider that your immune system is not working right, or that you cannot fight infection?

   ☐ Yes ☐ No ☐ Don't Know

3. In the last year, have you worked in a location where patients with active TB receive care of services?

   ☐ Yes ☐ No ☐ Don't Know

4. In the last year, have you lived with or had close contact with someone who has TB disease?

   ☐ Yes ☐ No ☐ Don't Know

5. In the last year, have you had an abnormal chest x-ray?

   ☐ Yes ☐ No ☐ Don't Know

6. In the last year, have you worked, volunteered, or lived in any institution such as another medical facility, jail, group home or homeless shelter?

   ☐ Yes ☐ No ☐ Don't Know

7. In the last year, have you traveled outside the United States?

   ☐ Yes ☐ No ☐ Don't Know If yes, where? _____

_____ _____

EMPLOYEE SIGNATURE DATE

(NOTE: This is to be completed by all new hires and annually thereafter.)