



Communicable Disease Screen

Please check one:

- Applicant/New Employee
- Existing Employee

As your employment entails that you have contact with health impaired clients, it is imperative that we are aware of any communicable disease you may have and take proactive steps to counter any possibility of transmission to clients. While the questions we ask below are personal in nature, it is important for the safety and well-being of our clients that you answer these questions honestly.

The information below will be used to determine the likelihood that you may have a communicable disease and for no other purpose. It will be reviewed by an independent registered nurse who will then make a determination if you must receive a communicable disease screen from a health care provider. All information you provide on this form will be viewed by the independent registered nurse only and strict confidentiality will be maintained.

Employee Number: _____ First and Last Initial: _____

Location: _____

General: The following will help us to assess your risk for a number of communicable diseases:

1.) Do you currently have any of the following diseases?

- | | | | | |
|--|-------|-----|-------|----|
| <input type="radio"/> Hepatitis | _____ | yes | _____ | no |
| <input type="radio"/> Measles | _____ | yes | _____ | no |
| <input type="radio"/> Meningitis | _____ | yes | _____ | no |
| <input type="radio"/> Whooping cough (Pertussis) | _____ | yes | _____ | no |
| <input type="radio"/> Small pox | _____ | yes | _____ | no |
| <input type="radio"/> Tuberculosis | _____ | yes | _____ | no |
| <input type="radio"/> Chickenpox | _____ | yes | _____ | no |
| <input type="radio"/> HIV/AIDS | _____ | yes | _____ | no |

For any "yes" responses, please provide details including date of diagnosis, treatment (if any) and prognosis: _____

2.) Have you had any of the following symptoms for more than two weeks?

- | | | | | |
|--|-------|-----|-------|----|
| <input type="radio"/> Fever | _____ | yes | _____ | no |
| <input type="radio"/> Severe fatigue | _____ | yes | _____ | no |
| <input type="radio"/> Significant loss of appetite | _____ | yes | _____ | no |

- Significant loss of weight (without meaning to) ___ yes ___ no
- Nausea ___ yes ___ no
- Vomiting ___ yes ___ no
- Abdominal pain ___ yes ___ no
- Dark urine ___ yes ___ no
- Jaundice ___ yes ___ no
- Drenching night sweats
(not related to menopause) ___ yes ___ no
- Coughing up blood ___ yes ___ no
- Lumps or swollen glands in the neck or armpits ___ yes ___ no
- Skin rash ___ yes ___ no
- Explosive coughing ___ yes ___ no
- Skin lesions or infections ___ yes ___ no

For any "yes" responses above, please describe your symptoms in more detail and indicate how long they have been present: _____

For any "yes" responses above which are related to a diagnosed medical condition, please provide the diagnosis: _____

- 3.) Have you had all of your childhood vaccinations? ___ yes ___ no
If not, please list those that you did not receive: _____

The following questions help us to assess your risk for HIV/AIDS, Hepatitis A, B and C:

- 1.) Have you ever shared needles or injecting "works" with other individuals, including your spouse or significant other, even once, even a long time ago? ___ yes ___ no
- 2.) Have you ever experienced other forms of blood-to-blood or bodily fluid exposure including:
- Blood transfusion or organ transplant before July 1992 ___ yes ___ no
 - Received blood clotting factor made before 1992 ___ yes ___ no
 - Been on hemodialysis ___ yes ___ no

- 3.) Have you ever had elevated liver enzymes or liver disease: ___ yes ___ no

If yes, please provide detailed information, including when, for how long and if condition has resolved.

- 4.) Have you ever had unprotected sex with anyone who has:

- Injected drugs ___ yes ___ no
- Many sexual partners ___ yes ___ no
- HIV or AIDS ___ yes ___ no

The following questions will help us to assess your risk for tuberculosis:

- 1.) Have you ever received treatment for TB disease? yes no
If yes, when and for how long? _____
- 2.) Within the last 6 months have you had close contact or lived with someone diagnosed with or being treated for TB? yes no
- 3.) Within the last 6 months, have you lived in a substance abuse treatment facility, homeless shelter, drug house, jail, or psychiatric hospital? yes no
- 4.) Within the last 6 months, have you traveled to areas with a high rate of TB such as Asia, Latin America, Africa or India? yes no

I certify that the above is true and accurate to the best of my knowledge:

Employee Signature

Date

Applicant/New Employee: Please fax completed form to 920-474-7508

Current Employee: Please mail completed form to:

Happy At Home
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