NYC – Metro Physician Services PC

CONSENT AND RELEASE FOR PRE-EMPLOYMENT DRUG SCREENING

I, ______________________________, understand that pursuant to Parker Jewish Institute and Rehabilitation Policy for a Drug and Alcohol-Free Workplace, I am being required to drug screening test.

I hereby consent to submit to urinalysis, blood, and/or other tests as shall be determined by Parker Jewish Institute and Rehabilitation for the purpose of determining the use of illegal drugs.

I agree that Testing Laboratory, or an alternate company selected facility, may collect these specimens for these tests and may test them or forward them to a testing laboratory designated by Parker Jewish Institute and Rehabilitation for analysis. I further agree to and hereby authorize the release of the results of said tests to Parker Jewish Institute and Rehabilitation.

I understand that it is the current illegal use of drugs and/or abuse of alcohol that prohibits me from obtaining employment with Parker Jewish Institute and Rehabilitation.

I am unaware of any medical condition that would indicate that either the screen or physical examination might endanger my physical health.

I agree to hold harmless Parker Jewish Institute and Rehabilitation and its agents (including the above named physician or clinic) from any liability arising in whole or part out of the collection of specimens, testing, and use of the information from said testing in connection with Parker Jewish Institute and Rehabilitation's consideration of my continuing employment.

I agree that a reproduced copy of this consent and release form shall have the same force and effect as the original.

I have carefully read the foregoing and fully understand its contents. I acknowledge that my signing of this consent and release form is a voluntary act on my part and that I have not been coerced into signing this document by anyone.

APPLICANT NAME (PRINTED): ____

APPLICANT SIGNATURE: ____

DATE: ______________________

Parker Jewish Institute for Health Care and Rehabilitation

Consent to Administer Or Refuse Hepatitis B Vaccine

Name____ Dept.____________________ Date_____________

Facts about the vaccine: The vaccine, RECOMBIVAX-HS, is intended to immunize against infection caused by the hepatitis virus. Some reactions have included injection site soreness, erythema (redness of the skin) and swelling – warmth or induration (hardness) but no serious adverse reactions have been reported. The symptoms of local inflammation generally subside within two days after being vaccinated. Low-grade fever (less than 101°F) occasionally occurs and although a fever of 102°F is uncommon, it has been reported. Other complaints have been malaise, fatigue, headache, nausea, vomiting, dizziness, myalgia (muscle pain), arthralgia (joint pain) and a rash. Neurological disorders such as parathesias (a burning, pricking sensation) and acute radiculoneuropathy {disease of the nerve and ner.ve roots) including 6uillain-Barre Syndrome has been rarely reported in temporal as association with administration of the vaccine, but no cause and effect relationship has been established.

Precautions: Immunization should be delayed where any seriously active infection exists, except when the withholding of the vaccine, in the opinion of the physician, entails a greater risk. Precaution should be exercised in administering it to individuals with severe cardiopulmonary problems. It is not known whether the vaccine can cause fetal harm when administered to a pregnant woman or whether it can affect reproductive capacity. It should, therefore, not be given to a pregnant woman unless clearly indicated. Caution should be exercised when· administering the vaccine to a nursing woman. HEPTAVAX-B has been shown to be well tolerated and effective in infants and children of all ages, including newborns. However, Hepatitis B Immune Globulin is currently the treatment of choice for infants born to Hepatitis B antigen-positive mothers.

Dosage: Three doses of RECOMBIVAX-HB are necessary to achieve immunity from the Hepatitis B virus. The first dose may be given at any elected date, the second dose must be given one month thereafter, and the third dose must be given six months after the first dose. Although the duration of protection provided by the vaccine is unknown at present, available data suggests that immunity will last for about five years in patients who have received all three doses. A single booster dose of vaccine may be necessary to maintain immunity; however, it may not prevent Hepatitis B in patients whose vaccine regimen began after an exposure to the virus has occurred.

Facts, benefits, alternatives. risks and complications: The facts, purposes, benefits and alternatives of administering the Hepatitis B vaccine have been explained to me. I have also been made aware of the risks, consequences and discomforts which may occur. I have read all of the above statements concerning the vaccine.

Voluntary Consent

I have read the information above and consent to receiving the vaccination.

Name (Print) ______________________________ Signature: __________________________________ Date: ______________

Hepatitis B Vaccine Refusal

I understand that due to my possible occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring the Hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with the Hepatitis B vaccine. However, I decline the Hepatitis B vaccination at this time. I understand that by declining the vaccine, 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 the Hepatitis B vaccine I may do so.

Name (Print) ______________________________ Signature: __________________________________ Date: ______________

Parker Jewish Institute
HEALTH CARE AND REHABILITATION

EMPLOYEE TUBERCULOSIS RISK ASSESSMENT SCREEN FORM

Name: ________________________________ Date: ____________________

Last TB Test Date: ____________________ Result: ____________________

- ☐ PPD
- ☐ Chest X-Ray
- ☐ Quantiferon

1. Is the employee taking any chronic steroids (equivalent to Prednisone> 15mg/day for more than one month) or immunosuppressive drugs, has Human Immunodeficiency Virus, or received an organ transplant?

   If yes, please explain:

2. Does the employee have Diabetes mellitus or blood/lymph disease such as Leukemia or Hodgkin's disease?

   If yes, please explain:

3. Does the employee have or had any of the following symptoms?

   Fever ....Yes ☐ No ☐ comments ______________________________
   Bloody sputum........................Yes ☐ No ☐ comments ______________________________
   Night sweats..........................Yes ☐ No ☐ comments ______________________________
   Loss of appetite..................... Yes ☐ No ☐ comments ______________________________
   Unexplained weight loss...........Yes ☐ No ☐ comments ______________________________
   Productive cough.................. Yes ☐ No ☐ comments ______________________________

4. Has the employee had close contact with someone who had TB disease? Yes ☐ No ☐
   If yes, please explain:

5. Does the employee have a history of TB? Yes ☐ No ☐
   If yes, please explain:

6. Does the employee have a history of positive PPD results? Yes ☐ No ☐
   If yes, please explain:

7. Is the employee a candidate for preventative therapy? Yes ☐ No ☐
   If no, please explain:

8. Does the employee have a history of temporary or permanent residence (for $\geq$ 1 month) in a country with a high TB rate (i.e. any country other than Australia, Canada, New Zealand, the United States, and those is Western Europe)?
   If yes, please explain:

Parker Jewish Institute
HEALTH CARE AND REHABILITATION

I certify that I have disclosed all known health conditions or TB related problems that may pose a potential risk to others or may interfere with the performance of my duties or services. I understand that failure to disclose requested medical information or giving false or misleading answers would be sufficient cause for my dismissal. I understand that this is a limited risk assessment solely for the purpose of determining fitness for employment and/or service.

Employee Signature: ______________________________________ Date: ____________________

Physicians Signature: ______________________________________ Date: ____________________