



Coral Springs Regional Institute of Public Safety

"Commitment to Excellence"

Patient Name:	DOB:	Age:	Sex:	Exam Date:
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ANNUAL PPD TB SKIN TEST

PPD/TB – Date Given: _____ / _____ / _____ M.A. Initials: _____

Date of Results (48-72 hrs.): _____ / _____ / _____ Negative Positive (>10mm) MD Initials: _____

(If Positive PPD) Chest X-Ray – Date Taken: _____ / _____ / _____ Results: Negative Other: _____ Provider Initials: _____

Vaccine:	Date: Month / Day / Year	Or Titer Results (titer results paperwork must be included)
Influenza	_____ / _____ / _____	Required if attending class during flu season, October 1 – March 31
MMR: Dose 1	_____ / _____ / _____	<input type="checkbox"/> Negative Immunity <input type="checkbox"/> Positive Immunity
MMR: Dose 2	_____ / _____ / _____	<input type="checkbox"/> Negative Immunity <input type="checkbox"/> Positive Immunity
Hepatitis B: Dose 1*	_____ / _____ / _____	<input type="checkbox"/> Negative Immunity <input type="checkbox"/> Positive Immunity
Hepatitis B: Dose 2*	_____ / _____ / _____	<input type="checkbox"/> Negative Immunity <input type="checkbox"/> Positive Immunity
Hepatitis B: Dose 3*	_____ / _____ / _____	<input type="checkbox"/> Negative Immunity <input type="checkbox"/> Positive Immunity
Varicella: Dose 1*	_____ / _____ / _____	<input type="checkbox"/> Negative Immunity <input type="checkbox"/> Positive Immunity
Varicella: Dose 2*	_____ / _____ / _____	<input type="checkbox"/> Negative Immunity <input type="checkbox"/> Positive Immunity

*DECLINE VARICELLA VACCINATION

I understand that due to my occupational exposure I may be at risk of acquiring the varicella-zoster virus (VZV). I have been given the opportunity to be vaccinated with the varicella vaccine; however, I decline varicella vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring varicella. By declining the varicella vaccine at this time I agree to hold harmless CSRIPS, their staff and all its agents. I decline the 2 Varicella Vaccine Injections

Patient Signature

Practitioner's Stamp

_____/_____/_____
Date

*DECLINE HEPATITIS B VACCINATION

I understand that due to my occupational exposure to blood or other potentially infectious materials I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine; however, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. By declining the hepatitis B vaccine at this time I agree to hold harmless CSRIPS, their staff and all its agents. I decline the 3 Hepatitis B Vaccine Injections

Patient Signature

Practitioner's Stamp

_____/_____/_____
Date

Referral and/or Follow Up Advised. (Please refer to patient's chart for more specific details)

I have found this student to be physically qualified having no current major health issue that would limit them from performing any CSRIPS clinical externship duties, and found them free of known communicable disease.

Practitioner's Signature

Practitioner's Stamp

_____/_____/_____
Date

MEDICAL RECORD RELEASE FORM: I hereby authorize the release of the information documented on the above form to the CSRIPS for the sole use of a general work physical and/or drug screen test:

Patient Signature

_____/_____/_____
Date

Immunization Guidelines

Tuberculosis: You must submit proof of A or B each year. If your PPD has a result of positive, you must submit C.

- A) A Negative PPD
- B) A Negative Quantiferon Gold TB Test
- C) A Negative Chest X-Ray dated within the last 3 years. Once your Chest X-Ray is a year old, you must submit a completed copy of the TB Screening Form.

If you have already been employed at Broward Health, you may also submit your Employee ID for compliance.

Hepatitis B: You must submit A OR B OR C

- A) 3 Hepatitis B Vaccinations. You will be compliant for 1 month after the first dose and 5 months after the second dose.
 - B) A positive Hepatitis B Titer
 - C) Hepatitis B Declination form completed by your physician.
- If you have already been employed at Broward Health, you may also submit your Employee ID for compliance.

Varicella: You must submit proof of A or B

- A) 2 Varicella vaccinations. You will be compliant for 1 month after the first dose.
- B) A positive Varicella Titer

You may also submit a declination for the Varicella vaccine.

If you have already been employed at Broward Health, you may also submit your Employee ID for compliance.

MMR: You must submit A or B

- A) 2 MMR Vaccinations. You will be compliant for 1 month after the first dose.
- B) Positive Measles, Mumps, and Rubella Titers

If you have already been employed at Broward Health, you may also submit your Employee ID for compliance.

Influenza: You must submit proof of a current Flu Shot beginning in October of each year. Flu season dates October 1 – March 31.

If you have already been employed at Broward Health, you may also submit your Employee ID for compliance.