

**Westchester County Department of Health – Health Information Form**

Name: \_\_\_\_\_ Discipline: \_\_\_\_\_ License/Certification #: \_\_\_\_\_  
 (Print Name)

**REQUIRED**

**I. Tuberculin Skin Test -Mantoux/Intermediate PPD required every year:**

A. Date test administered: \_\_\_\_\_ Date test read: \_\_\_\_\_ Results: \_\_\_\_\_ mm duration

B. If previous tests were negative and the last test was positive, indicate if follow-up Chest x-ray was done.

Date: \_\_\_\_\_ Normal  Abnormal  Follow-up/treatment if indicated: \_\_\_\_\_

II. **Measles, Mumps, Rubella (MMR)** Date of immunization(s): \_\_\_\_\_ Date of titer/results: \_\_\_\_\_  
 (Individuals born before 1957 are considered immune to measles/mumps.)

**Recommended Physical Examination**

**(This form should be completed by your Primary Care Provider)**

In compliance with the New York State “Health and Safety Standards for Early Intervention Program” Guidance Document, I have examined the above named individual and found that this individual has no diagnosed disorder that would preclude him/her from providing services and is free from communicable disease.

Primary Care Provider’s (stamp):

(Name)	(Primary Care Provider Signature)	(Date)
(Address)	(Date of Exam)	

**RECOMMENDED IMMUNIZATIONS/TITERS**

Hepatitis B (Indicate dates of all three vax): \_\_\_\_\_  
 (Date) (Date) (Date)

Tetanus within past 10 yrs (Td): \_\_\_\_\_  
 (Date)

Or

Tetanus/Diphtheria/Pertussis (Tdap): \_\_\_\_\_  
 (Date)

Varicella: \_\_\_\_\_  
 (Date)

Influenza: \_\_\_\_\_  
 (Date)

**DRUG/ALCOHOL DECLARATION**

I am not habituated or addicted to depressants, stimulants, narcotics, alcohol or other substances nor do I have a physical or emotional condition that may alter my behavior, interfere with the performance of my duties or pose a potential risk to patients. The responses above are true to the best of my knowledge. I understand that any omissions, error and/or misstatement of facts may be grounds for termination of my WCDH contract.

Individual Provider’s Signature \_\_\_\_\_ Date: \_\_\_\_\_