MedAmerica
PHYSICIAN PRACTICE PARTNERS

Current Date _____

Date of Injury _____

Company Name Campbell Union High School District

Contact Person Monica Torres / Laura Padilla

Contact Phone (408) 371-0960 Fax (408) 371-0673

x2020/2029

LOCATIONS:

GATEWAY FAMILY MEDICAL CENTER
1580 S. Winchester Blvd., Ste. 202
Campbell, CA 95008
408-364-7600

SAMARITAN MEDICAL CARE CENTER
554 Blossom Hill Road
San Jose, CA 95123
408-281-2772
Open Saturday's 9:00am to 5:00pm

SOUTH VALLEY FAMILY & OCCUPATIONAL HEALTH CENTER
9460 No Name Uno, Ste. 230
Gilroy, CA 95020
408-842-1544

EMPLOYEE NAME: _____

AUTHORIZED BY: Meredyth Hudson, Chief Human Resources Officer

EXAMINATIONS AND SERVICES:

- ☐ INJURY TREATMENT
- ☐ PRE-EMPLOYMENT PHYSICAL
- ☐ DMV/DOT PHYSICAL
- ☐ RESPIRATORY CLEARANCE
- ☐ AUDIOMETRY
- ☐ SPIROMETRY
- ☒ PPD Skin Test **
- ☐ Lab _____
- ☐ _____
- ☐ X-RAY
  Type _____

ERGONOMIC TESTING: ☐ Lift Test ☐ Step Test

STORE # _____

DRUG SCREEN: ☐ DRUG SCREEN *(Check Reason Below)*
☐ DOT ☐ NON-DOT

BAT: ☐ BAT (Breath Alcohol Test)
(Check Reason Below)

REASON:
- ☐ Pre-Placement
- ☐ Post Accident
- ☐ Random
- ☐ Reasonable Suspicion
- ☐ Return to Duty

MODIFIED WORK AVAILABLE? ☐ Yes ☐ No

COMMENTS: **** If skin test is positive and requires subsequent chest x-ray, authorization is hereby given for the required x-ray by the Campbell Union High School District.**

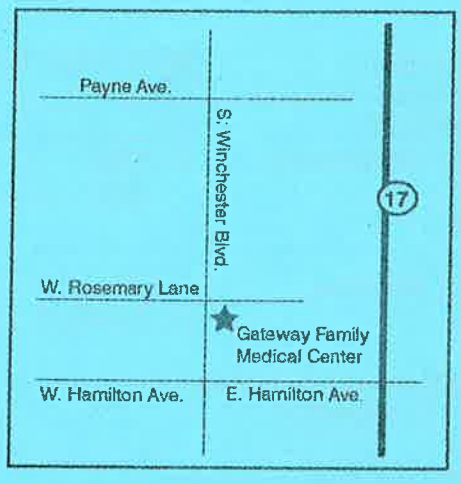
Tuberculosis Test

Education Code 49406 requires that all school district employees undergo an examination (skin test or x-ray) at least once every four years to certify tuberculosis clearance.

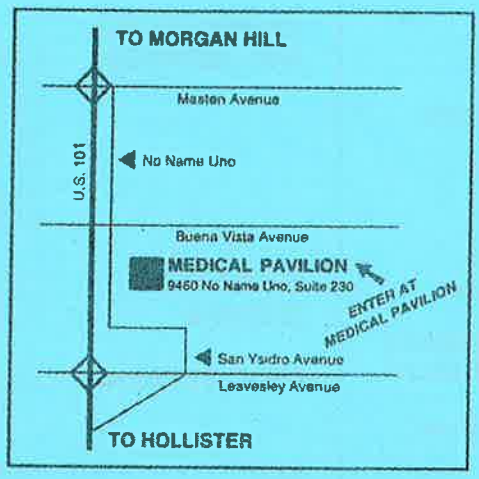
You may go to Gateway Family Medical Center at: 1580 Winchester Blvd., Suite 202
Campbell, Ca 95008
(408) 364-7600

or you may go to Samaritan Medical Care Center at: 554 Blossom Hill Road
San Jose, CA 95123
(408) 281-2772

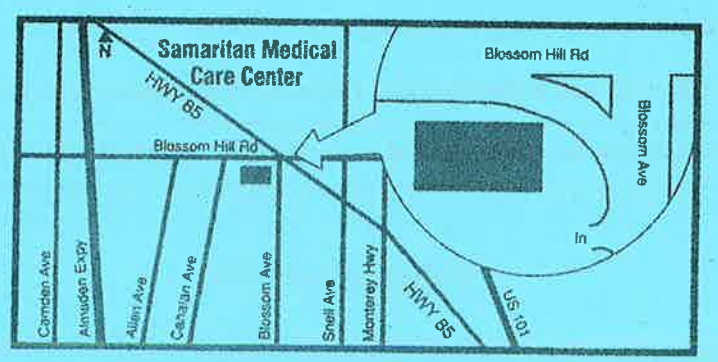
Directions to the above two authorized sites are on the reverse side of this form. Should you have any questions, please contact the Campbell Union High School District Human Resources office at (408) 371-0960.



1580 S. WINCHESTER BLVD., SUITE 202
CAMPBELL, CA 95008



9460 NO. NAME UNO, SUITE 230
GILROY, CA 95020



554 BLOSSOM HILL ROAD
SAN JOSE, CA 95123

Adult Tuberculosis (TB) Risk Assessment Questionnaire[1]

(To satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555)

To be administered by a licensed health care provider (physician, physician assistant, nurse practitioner, registered nurse)

Name: _____ Date of Risk Assessment: _____

Date of Birth: _____

History of positive TB test or TB disease Yes ☐ No ☐

If yes, a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire.*
If no, continue with questions below.

If there is a "Yes" response to any of the questions 1-5 below, then a tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) should be performed. A positive test should be followed by a chest x-ray, and if normal, treatment for TB infection considered.

Risk Factors	
1. One or more signs and symptoms of TB (prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue) Note: A chest x-ray and/or sputum examination may be necessary to rule out infectious TB.[2]	Yes ☐ No ☐
2. Close contact with someone with infectious TB disease	Yes ☐ No ☐
3. Birth in high TB-prevalence country** (**Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes ☐ No ☐
4. Travel to high TB-prevalence country** for more than 1 month (**Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	Yes ☐ No ☐
5. Current or former residence or work in a correctional facility, long-term care facility, hospital, or homeless shelter	Yes ☐ No ☐

**Once a person has a documented positive test for TB infection that has been followed by an x-ray that was deemed free of infectious TB, the TB risk assessment is no longer required.*

[1] Adapted from a form developed by Minnesota Department of Health TB Prevention and Control Program and Centers for Disease Control and Prevention.

[2] Centers for Disease Control and Prevention (CDC). *Latent Tuberculosis Infection: A Guide for Primary Health Care Providers*. 2013. (http://www.cdc.gov/tb/publications/LTBI/default.htm)

CDPH California Department of Public Health

CTCA California Tuberculosis Controllers Association

ADULT TUBERCULOSIS (TB) RISK ASSESSMENT QUESTIONNAIRE

(To satisfy California Education Code Section 49406 and Health and Safety Code Sections 121525-121555)

CERTIFICATE OF COMPLETION

To be signed by the licensed health care provider completing the risk assessment and/or examination

Name: _____ **Date:** _____

Date of Birth: _____

The above named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.

_____

Health Care Provider Signature

_____

Please Print Health Care Provider Name **Title**

_____

Office Address: Street **City** **State** **Zip Code**

_____

Telephone **Fax**