



Employee / Student Health

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State University of New York

Upstate Medical University

DETAILED HEALTH STATEMENT (>3 days)

ALL SPACES MUST BE COMPLETED

Name: _____ Sex M F Date of Birth: _____
Institution or Agency: _____ Social Security #: _____
Contact Person: _____ Phone Number: _____
Dept. Location: _____ Hospital Other
Contact Person: _____ Phone Number: _____
Position: _____ Start Date: _____ Exit Date: _____
Local Address: _____ Telephone #: _____

It is the responsibility of all observers to be free of communicable disease, which could potentially jeopardize the health of patients and personnel. Please read and sign the following statement.

1. Do you now have or have you been treated for any contagious illness within the last year? Yes No
2. Do you have any type of skin infection or open (non-healing) areas on your body surface? Yes No
3. Have you had any recent weight loss, cough, fever and/or night sweats? Yes No
4. Is there any additional pertinent information regarding your health? Yes No
5. How would you describe your health? _____
6. Please respond to any "yes" answers: _____

I attest that I am free of any communicable disease, including respiratory illness and/or skin infection, to the best of my knowledge. (Parent or legal guardian must sign for those under 18 years of age.)

Signature _____ Date _____

TUBERCULIN SKIN TEST: (TST) (required within 1 year prior to assignment) (TST, Mantoux only, Tine test unacceptable)

- Date given: _____ Product Manufacturer: _____ Lot #/Expiration Date: _____
- Date read: _____ Results: _____
- **If previous TST was positive**, Date of conversion: _____ Reaction: _____ mm
- **Chest x ray is required** for those who are TST positive (required within 6 months of starting)
Date: _____ Result: _____ (Report must be enclosed)
- **Was treatment taken for a positive TST** Yes No
Drug: _____ Date Started: _____ Date Completed: _____

RUBELLA: (German Measles) Antibody Titer Date: _____ Result: _____

RUBEOLA: (Measles) (If born on or after January 1, 1957)

- Antibody Titer Date: _____ Results: _____

VARICELLA: (Chicken Pox/Shingles) Disease: Yes No

- Blood test needed if no history of disease Antibody Titer Date: _____ Result: _____

TETANUS/DIPHTHERIA: (recommended within 10 years) Date of last immunization: _____

Print Name of HCP Completing form: _____ Title: _____

Signature of Health Care Provider: _____ Date: _____

RETURN TO: Employee/Student Health Office, Jacobsen Hall,
SUNY Upstate Medical University,
750 East Adams Street. Syracuse, NY, 13210.

FOR HEALTH SERVICES

Reviewed by: _____
Date: _____
Comments: _____