

**Detailed Health Statement**

**For Non-Employee Medical Clearance**

*(If affiliation is less than one month in duration)*

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_

Contact Phone (Cell) Number: \_\_\_\_\_ Start Date: \_\_\_\_\_ Exit Date: \_\_\_\_\_

Job Title or Activity: \_\_\_\_\_ Patient contact anticipated? \_\_\_\_\_

E-mail address: \_\_\_\_\_

**FROM: (Current Organization)**

**TO: (Upstate)**

|                                  |                           |
|----------------------------------|---------------------------|
| Employer or Program              | Upstate Dept. or Program  |
| Contact Person from Organization | Contact Person at Upstate |
| Contact Person Phone No.         | Upstate Contact Phone No. |

**In the past year, have you had:**

1. Contagious or communicable illness? .....  Yes  No
2. Skin infection or open (non-healing) wounds? .....  Yes  No
3. Recent weight loss, cough, fever, and or night sweats? .....  Yes  No

Detail any "Yes" responses: \_\_\_\_\_

**To the best of my knowledge the information above is accurate and truthful.**

**Signature:** \_\_\_\_\_

| To be completed by Health Care Provider   |  |
|---|--|
| <b>Required:</b>  |  |
| Tuberculin Mantoux Skin Test: (TST) (required within 1 year of assignment)          |  |
| Date Admin.: _____  | Manufacturer: _____ Lot/Exp.No.: _____ |
| Date Read: _____  | Reaction (mm): _____                   |
| Chest X Ray if positive TST within 1 year of assignment: (Report must be attached): |  |
| Date: _____   |  |
| Rubella (German Measles): IgG antibody titer (blood test):                          | Date: _____ Result: _____              |
| Rubeola (Measles): IgG antibody titer (blood test):                                 | Date: _____ Result: _____              |
| <b>Recommended (not required):</b>  |  |
| Mumps: IgG antibody titer (blood test):   | Date: _____ Result: _____              |
| Varicella (Chicken Pox): IgG antibody titer (blood test):                           | Date: _____ Result: _____              |
| Varicella Disease History: <input type="checkbox"/> Yes <input type="checkbox"/> No |  |

**Verification of Information by Health Care Provider:**

**Signature:** \_\_\_\_\_ **Stamp:** \_\_\_\_\_

**Date:** \_\_\_\_\_

ESH Clearance: \_\_\_\_\_