C.A.R.E.S.

Empowering individuals with developmental disabilities to connect with their community.

105 W. Broad St., Suite 200
Tamaqua, PA 18252

(570)225-7360

TO: All Prospective and Current C.A.R.E.S. Employees

RE: Medical Examinations

All new employees are required to have a physical examination after being offered a position with CARES. New employees may not attend orientation until we receive the results of their physical examinations and Mantoux tests. Physical examination results will be kept confidential.

Physical examinations must include:

1. General physical examination
2. Mantoux test
3. Clearance to perform the essential functions of the job as indicated in the job description;
4. Statement indicating the patient is free from communicable diseases or is aware of the precautions necessary to protect others
5. Signature of Physician

Subsequent physical examinations and Mantoux tests are required in accordance with your program's policy and licensing regulations.

Chest x-rays are ordered as a result of a reaction to a Mantoux test. ***No additional testing is required by CARES.*** Except for random drug screens as assigned, any other testing performed will be at your expense and will not be reimbursed.

Please contact Human Resources at 570-225-7360 if you have any questions.

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Employee Physical Evaluation Report

Employee Information *(to be completed by employee)*

Last Name:_____ First Name:_____ Date:_____

Age:_____ Sex:_____ Social Security Number:_____

Address:_____ City:_____

State:_____ Zip:_____ Phone:_____

In case of emergency notify – Name:_____ Phone:_____

Personal physician – Name:_____ Phone:_____

Address:_____

_____

Clinical Impressions/Work Restrictions *(to be completed by physician)*

- **As far as can be determined from this examination, is the patient able to perform the job duties as described?**

  _____Yes _____No

- **As far as can be determined from this examination, is the patient free and clear of all communicable diseases and/or medical problems which might interfere with the health, safety, or well-being of other individuals?**

  _____Yes _____No

If no, what precautions need to be taken or what other information is necessary to ensure the health/safety of other individuals?

_____

_____

Laboratory Work Ordered:

Mantoux test location: _____ Mantoux test results: _____

Date applied: _____ Date read:_____

_____ _____ _____

Signature of Physician, Certified Nurse Practitioner or Registered Assistant

Date

Print or Stamp Name

_____

Address

_____

City, State, Zip

Please return to
CARES
105 W. Broad
Suite 200
Tamaqua PA 18252

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Employee Physical Evaluation

Please complete and submit this section to your physician.

Health History *(to be completed by employee)*

Name:_____ Date of Birth:_____

Allergies/Contraindicated Medications:_____

Current Medications:_____

Immunizations

Type	Yes	No	Type	Yes	No	Type	Yes	No
Flu			Measles			Polio		
Tetanus			Mumps			Hepatitis		
Diphtheria			Rubella			Other		

Health over the last year:_____

_____

Chronic Conditions/Present Illnesses:_____

_____

Please check any symptoms or conditions that you have experienced:

Seizures		Chorea		Hypertension		Diabetes		Stroke	
Rheumatic Fever		Cancer		Drug Allergy		Asthma		Back Injury	
Hepatitis		Mumps		Tonsillitis		Typhoid		Meningitis	
Diphtheria		TB		Measles		Pneumonia		Other	

Please describe any checked items:_____

_____

Previous surgery or hospitalizations/other conditions:_____

_____

Have you filed or been treated for a work-related injury with any past employer? _____No _____Yes

If yes, please list all injuries, dates, employers:_____

_____

Patient Authorization/Certification

I, the undersigned, do hereby certify that the information provided on this form is true to the best of my knowledge and understand that any falsification, misrepresentation or omission, concerning permission for the results of my medical examination and for the personal medical history, including but not limited to any and all information related to drug/alcohol use, abuse and or treatment and/or mental health diagnosis and or treatments that I have completed, to be transmitted to the relevant personnel.

Signature: _____ Date: _____

Printed Name: _____

Clinical Evaluation *(to be completed by physician)*

Height: _____ Weight: _____ Blood Pressure: _____

Please check each item:

Area	Normal	Abnormal	Describe Abnormal Findings
Head/Neck			
Eyes			
Ears			
Nose			
Mouth			
Throat			
Teeth			
Chest/Lungs			
Breasts			
Heart			
Abdomen			
Hernia			
Arms			
Hands			
Legs			
Feet			
Spine			
Skin			
Lymph Nodes			
Neurological			

Notes: _____

_____

_____ _____

Signature of Examining Physician **Physical Date**

Please retain clinical evaluation in patient chart. Return to employee/employer.