

# Pre-placement Screening Medical Review Form

## University of Florida

Please complete the following four pages and place in the enclosed envelope and return to the Student Health Care Center Occupational Medicine by May 1st. The information requested on these pages is necessary in order to minimize any occupational risks to you and to insure that you can safely perform the essential functions of your new job. Section I: Medical History information on this form will be kept in a confidential file at the SHCC, and will not be shared with your Employer, Program or Director without your written permission/consent. Your signature in Section II: Consent to Release Records authorizes the release of Section III Immunization Documentation to your Program and the Occupational Medicine Department of your work site.

Name: \_\_\_\_\_ SS#: \_\_\_\_\_  
(Last, First, Middle Initial)

Date of Birth: \_\_\_\_\_ Job Title: \_\_\_\_\_  
(mm / dd / yy)

Work Site - Gainesville: \_\_\_\_\_ Jacksonville: \_\_\_\_\_ Other: \_\_\_\_\_

Position Number (if known): \_\_\_\_\_ UF ID (if known): \_\_\_\_\_

Department: \_\_\_\_\_ Supervisor/Prog Director: \_\_\_\_\_

### Section I - Medical History

Do you have now, have you ever had, or have you received treatment for the following:

Yes	No		If YES use as many lines below as needed to explain
		<b>Hospitalizations/Surgeries</b>	_____
			_____
			_____
			_____
		<b>Current Medications: doses and Frequency</b>	_____
			_____
			_____
<input type="checkbox"/>	<input type="checkbox"/>	Visual loss (one or both eyes)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Blindness	_____
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty hearing/hearing aides	_____
<input type="checkbox"/>	<input type="checkbox"/>	Deafness	_____
<input type="checkbox"/>	<input type="checkbox"/>	Allergic rhinitis/allergies	_____
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis (type)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other liver disease (type)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (type)	_____
<input type="checkbox"/>	<input type="checkbox"/>	Carpal tunnel syndrome	_____
<input type="checkbox"/>	<input type="checkbox"/>	Other hand/wrist problems	_____
<input type="checkbox"/>	<input type="checkbox"/>	Back or neck injury	_____
<input type="checkbox"/>	<input type="checkbox"/>	Chronic back pain	_____

Date SHCC Received \_\_\_\_\_



Name: \_\_\_\_\_ SS#: \_\_\_\_\_

**Section III - Immunization Documentation - must be completed by physician or authorized clinic personnel**

**Section A - Vaccination or documentation of Immunity required**

**EITHER MMR Combined (Measles, Mumps, and Rubella): Two doses are required.**

Month	Day	Year

1st dose received at 12 months of age or later AND in 1971 or later  
2nd dose received at least 30 days after 1st dose

**OR:**

**MEASLES (Rubeola):**

Month	Day	Year

1st dose at 12 months of age or later AND in 1968 or later  
2nd dose received at least 30 days after 1st dose  
Titer or Results \_\_\_\_\_

**AND MUMPS:**

Month	Day	Year

Received at 12 months of age or later  
Titer or Results \_\_\_\_\_

**AND RUBELLA (German Measles):**

Month	Day	Year

Received at 12 months of age AND in 1969 or later  
Titer or Results \_\_\_\_\_

**TUBERCULOSIS (PPD test by Mantoux):**  
**PPD must be current within the next year**

**IF POSITIVE PPD Chest X-Ray Required – note date below and attach chest x-ray results:**

1<sup>st</sup> PPD Given 

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1<sup>st</sup> PPD Read 

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PPD Results: \_\_\_\_\_ mm  negative  positive

2<sup>nd</sup> PPD Given 

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2<sup>nd</sup> PPD Read 

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*(if 1<sup>st</sup> test is negative, a second test MUST be done within 1-3 weeks)*  
PPD Results: \_\_\_\_\_ mm  negative  positive

**HEPATITIS B: Series of three doses (Required only if there will be blood/body fluid exposure.)**

#1 

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#2 

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#3 

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Booster 

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Titer 

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Results: \_\_\_\_\_

**CHICKENPOX (Varicella): Vaccination, titer, or had disease. (TWO shots required IF 1<sup>st</sup> is before age 13)**

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Varivax #1

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Varivax #2

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Titer Result \_\_\_\_\_

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Hx of Disease

**Section B - RECOMMENDED**

**TETANUS/DIPHTHERIA:**

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**Booster within the last 10 years**

Office Stamp/Name of Clinic or Physician

Physician or Authorized Signature

Date

**Incomplete or absent immunizations may be provided by the University of Florida and can be obtained at Student Health Occupational Medicine prior to beginning job duties that include patient contact exposures.**



**RESIDENT/FELLOW**