Pals Staffing Services Inc.

1200 Markham Rd. Suite 509, Scarborough, Ontario,M1H 3C3
Tel: (416) 431-7788,(416) 431-4131, Fax: (416) 431-7717

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STAFF MEDICAL INFORMATION FORM

The individual named below has registered with our agency as a health care giver, social worker or child and youth worker which will require him/her to work with people who because of their age, disability or other circumstances whether temporary or permanent are in a position of dependence on others and otherwise at a greater risk than the general population of being infected with communicable and or contagious disease.

EMPLOYEE INFORMATION

Name : _____

DOB: _____ Gender: _____

Address : _____

Phone No : _____

Physician's Name: _____

IMMUNIZATION

The following tests and immunizations are required before staff's placement at any of Pal's agency.

a. Tetanus/Diphtheria Absorbed vaccine
(every 10 years following primary series) _____ Date of vaccination

b. Polio vaccine
(every 10 years following primary series) _____ Date of vaccination

c. Measles, Mumps, Rubella (MMR)
(documented proof of having had disease or proof of vaccination against disease) _____ Date of vaccination

d. Influenza vaccine
(or other recognizable antiviral prophylaxis) _____ Date of vaccination

e. Tuberculin Test (proof of Two-Step Mantoux test with PPD/5TU)
If positive Mantoux Skin Test, proof of negative Chest X-ray _____ Date
Result :_____

f. C.B.C. and Urinalysis
Result :_____ _____ Date

g. Blood Pressure _____ Pulse : _____

h. Has the Candidate been tested for Hepatitis B? Yes _____ No _____
If yes, has he/she been found to be:
a. Immune to Hepatitis B ( )
b. Susceptible to Hepatitis B ( )
c. A carrier of Hepatitis B ( )
d. Infected with Hepatitis B ( )

Has candidate received Hepatitis B vaccination? Yes ____ No _____
If yes : Vaccination Schedule for Hepatitis B:

Dose _____ Injection Date completed _____ Lot no. _____

1st _____ 2nd _____ 3rd _____

PHYSICAL EXAMINATION

To your knowledge, does this individual have any history of the following?

Sensory (vision and hearing)	Yes ____ No ____	Lower back pain	Yes ____ No ____
Back injury	Yes ____ No ____	Chemical dependency	Yes ____ No ____
Epilepsy	Yes ____ No ____	Cardiovascular	Yes ____ No ____
Musculoskeletal	Yes ____ No ____		

Any other: (please describe)

_____

_____

Are there conditions restricting his/her physical ability to work?

_____

_____

GENERAL ASSESSMENT

In general, to the best of your knowledge, does this candidate have any medical or other condition(s) such as other communicable disease like SARS, bird flu, etc. which would preclude or restrict his/her performing duties/ responsibilities in the health care, social work and child youth work field?

Yes _____ No _____

If yes, please specify:

_____

_____

_____

Physician's Name and Address: (please print)

_____

_____

_____

_____

_____

_____ _____

Physician's Signature Date