THE UNIVERSITY OF MISSISSIPPI
MEDICAL CENTER
EDUCATION • RESEARCH • HEALTH CARE

Student Employee Health
2500 North State Street, Room N-136
Jackson, Mississippi 39216
Phone: 601.984.1185 • Fax: 601.984.1189

Student Employee Health

Welcome to the University of Mississippi Medical Center! We are very pleased that you have chosen to join our team and contribute to our mission. We wish you many years of success with us. To help keep track of all the activities that are required of new employees, we would like you to have the following information. All of this should be completed within the first two weeks of your employment. It is your responsibility to complete these requirements in order to continue employment.

Who:

All new employees without exception must report to the Student Employee Health Clinic during the first week of employment. During your visit, you will get a TB skin test and will be directed to the Outpatient Lab to have your blood drawn. You will be given an appointment card for your physical examination. If you need to cancel your appointment, please call us the day before and reschedule your appointment, 601-984-1186. **Temporary employees need TB testing and OSHA forms completed by supervisor only.**

What:

TB Test – All new employees are required to have a two-step TB skin test. If you have had a TB test within the past year, you must give us documented proof in order for us to waive the second TB test.

Blood Draw – New employees (full time and part time) need to get some blood work done. We will check blood titers depending upon what vaccines and diseases you have had in the past.

Physical Exam – A physical exam must be completed and certain vaccines will be provided to you at no charge, depending on your job duties and the information provided on your OHSA Category Form (which should be completed and signed by your supervisor) prior to your employment physical exam.

Where:

Student Employee Health, Room N-136, where your pre-employment drug screen was performed. **601-984-1186.**

When:

All new employees must process through Student Employee Health during the **first week of employment** for the required preliminary health workup. Please come to our clinic **when you are released from Orientation**. We do not give TB skin tests on Thursdays. It would be best to come on Tuesday, Wednesday, or Friday. You should arrive before 3:00 PM to allow enough time, but **do not miss any portion of your Orientation**. Our hours are Monday through Friday, 7:00 AM-5:00 PM.

Contract workers do not process through Student Employee Health.

CONFIDENTIAL

UMMC EMPLOYEE ID NUMBER: _____

STUDENT-EMPLOYEE HEALTH
NEW EMPLOYEE PATIENT REGISTRATION FORM

Each new employee will be scheduled for an employment physical. Please complete this form and the "New Employee Health Requirements Questionnaire". Submit both forms to the nurse during new employee orientation.

PLEASE PRINT OR TYPE

Temporary New Employee Former Employee

Patient Information:

Birth Date: _____ Hire Date: _____ Your Gender: _____ Soc Sec #: _____

Last Name: _____ Maiden Name: _____

First Name: _____ Middle Name: _____

Street Address: _____
(**NO** P.O. Box or RR #) City State Zip

Daytime Telephone: _____ Evening Telephone: _____

Marital Status: _____ M. S. W. D. Mother's Maiden: _____

Religion: _____ Ethnicity: _____ Primary Language: _____

Emergency Contact:

Relationship to Patient: _____

Last Name: _____ First Name: _____

Address: _____
Street Address City State Zip

Home Telephone: _____ Other Telephone: _____

UMMC History Information:

Previous UMMC Employee? Yes No If so, under what name? _____

Year employment ended: _____

UMMC student? Current Previous If so, under what name? _____

Year of graduation or last date of attendance? _____

Employment Information:

Title: _____ Department: _____

Supervisor Name: _____ Phone _____

CONFIDENTIAL

UMMC EMPLOYEE ID NUMBER: _____

STUDENT-EMPLOYEE HEALTH
NEW EMPLOYEE HEALTH REQUIREMENTS QUESTIONNAIRE

COMPLETE THIS FORM BEFORE NEW EMPLOYEE ORIENTATION DAY. SUBMIT FORM TO THE NURSE IN THE CLASSROOM DURING NEW EMPLOYEE ORIENTATION. BRING HEALTH RECORDS (Form 121 or vaccine records).

PLEASE NOTE: Each new employee will be scheduled for an employment physical. Please complete this form and the "New Employee Patient Registration Form". Submit both forms to the nurse during new employee orientation. Bring vaccine records, blood titer results, most recent chest x-ray, and TB screen reports (if applicable). By completing the following information, you are helping us determine which tests you will need for employment. Thank you.

PLEASE PRINT OR TYPE

LAST NAME: _____ FIRST NAME: _____ MI _____

PLEASE PLACE A CHECK MARK IN THE BOXES TO INDICATE YOUR RESPONSES:

1. Are you allergic to anything? .....YES ☐ NO ☐
   a. If so, please list here: _____
2. Do you have a latex allergy? .....YES ☐ NO ☐
3. Are you pregnant? .....YES ☐ NO ☐
   a. If yes, due date: _____
4. Have you ever had a TB Skin Test? .....YES ☐ NO ☐
   a. If yes, how was the test performed? TB skin test TB blood test
   b. When? _____
   c. Have you ever been treated for TB? .....YES ☐ NO ☐
   d. If yes, when? _____
5. Have you ever had chicken pox? .....YES ☐ NO ☐
   a. Have you ever had chicken pox vaccine? ..... YES ☐ NO ☐
   b. How many chicken pox vaccines did you receive? ☐1 ☐2
6. Have you ever received the Hepatitis B vaccines? .....YES ☐ NO ☐
   a. If yes, how many doses?: ☐1 ☐2 ☐3
7. Have you ever received measles, mumps, and rubella vaccine (MMR)? .....YES ☐ NO ☐
   b. If yes, how many doses?: ☐1 ☐2
8. Have you had a flu vaccination for the current flu season? .....YES ☐ NO ☐
9. Have you ever received a Tetanus vaccination? .....YES ☐ NO ☐
   a. If so, date of last dose: _____
10. Have you ever received Tdap vaccination?.....YES ☐ NO ☐
    a. If so, when: _____

If you answer "Yes" to any question(s), please attach your vaccination record and or titer results for verification of vaccinations. Additionally, please include last TB screen report.

PRE-PLACEMENT EMPLOYEE PHYSICAL EXAMINATION
STUDENT EMPLOYEE HEALTH

Date _____

LAST NAME | FIRST NAME | MIDDLE NAME | DATE OF BIRTH

HOME ADDRESS (Street, City, & State) | HOME PHONE | WORK PHONE

GENDER | RACE | MARITAL STATUS (M, S, W, D) | WHICH FOREIGN COUNTRIES HAVE YOU VISITED IN THE PAST 5 YEARS?

STATEMENT OF YOUR PRESENT HEALTH IN YOUR OWN WORDS (If ill health currently exists, please explain. Additional space provided on page 2.)

Will you be able to perform all the essential functions of your job? ☐ NO ☐ YES If no, please explain:

LIST ALL MEDICATIONS YOU ARE TAKING _____

ARE YOU ALLERGIC TO ANY MEDICATION? NO ☐ YES ☐

WHAT:_____

DO YOU HAVE ANY OTHER ALLERGIES? NO ☐ YES ☐

WHAT:_____

DO YOU HAVE A LATEX ALLERGY? NO ☐ YES ☐

DO YOU USE TOBACCO? NO ☐ YES ☐

HOW MUCH? _____

DO YOU HAVE ANY CONTRAINDICATIONS TO THE FLU VACCINE? ☐ NO ☐ YES

WHEN DID YOU HAVE THE FOLLOWING?

CHEST X-RAY _____ WHERE_____

T.B. SKIN TEST DATE_____ RESULT_____

TB Blood Test: Positive Negative

MMR IMMUNIZATION DATES: 1. _____ 2. _____

VARICELLA IMMUNIZATION DATES: 1. _____ 2. _____

TETANUS IMMUNIZATION DATES_____

Tdap IMMUNIZATION DATES_____

HEPATITIS B VACCINATION _____

YEAR SERIES COMPLETED _____

Were you born between 1945-1965? ☐ NO ☐ YES

Have you been screened for Hepatitis C? ☐ NO ☐ YES

HAVE YOU EVER HAD OR HAVE NOW (Place check at LEFT of each item). ANSWER ALL QUESTIONS.

YES	NO	(Check each item)	YES	NO	(Check each item)	YES	NO	(Check each item)	YES	NO	(Check each item)
○	○	Appendicitis	○	○	Dizziness or fainting spells	○	○	High blood pressure	○	○	Rheumatoid Arthritis
○	○	Arthritis	○	○	Ear, nose, throat trouble	○	○	HIV/AIDS	○	○	Seizure disorder
○	○	Asthma	○	○	Eye infection	○	○	Insomnia	○	○	Severe tooth or gum trouble
○	○	Back injury	○	○	Foot pain	○	○	Joint pain	○	○	Shortness of breath
○	○	Bleeding Disorders	○	○	Frequent indigestion	○	○	Kidney stones	○	○	Sinusitis
○	○	Boils	○	○	Frequent or painful urination	○	○	Leg cramps	○	○	Soaking sweats (night sweats)
○	○	Bursitis	○	○	Gall stones	○	○	Measles	○	○	Substance abuse
○	○	Cancer	○	○	German measles (Rubella)	○	○	Memory loss	○	○	Thyroid disease
○	○	Chest pain	○	○	Glaucoma	○	○	Motion Sickness	○	○	Transgender
○	○	Chicken pox	○	○	Hay fever	○	○	Mumps	○	○	Tuberculosis
○	○	Chronic back pain	○	○	Headaches	○	○	Other GI Complications	○	○	Venereal Disease
○	○	Chronic cough	○	○	Hearing loss	○	○	Palpitations	○	○	Whooping Cough
○	○	Chronic kidney disease	○	○	Heart disease	○	○	Paralysis			
○	○	Chronic or frequent colds	○	○	Hemorrhoids	○	○	Pregnancy			
○	○	Depression	○	○	Hepatitis	○	○	Recent weight loss/gain			
○	○	Diabetes mellitus	○	○	Hernia	○	○	Rheumatic fever			

HAVE YOU EVER (Check each item)

○	○	Attempted suicide	○	○	Stuttered ot stammered	**Females only** Have you ever been pregnant?_____ Times _____ Date of last period _____ Are you, or do you think you might be pregnant now?_____
○	○	Been a sleep walker	○	○	Worn a brace or back support	
○	○	Bled excessively after injury or tooth extraction	○	○	Worn an artificial eye	
○	○	Coughed up blood	○	○	Wore glasses or contact lenses	
○	○	Lived with anyone who had tuberculosis	○	○	Worn hearing aids	Are you (check one) ☐ Right handed ☐ Left handed

CHECK EACH ITEM YES OR NO. EVERY ITEM CHECKED "YES" MUST BE FULLY EXPLAINED BELOW.

○	○	Have you been unable to hold a job because of: A. Sensitivity to chemicals, dust, sunlight, etc.	○	○	Have you ever been a patient in a mental hospital? (If yes, specify when, where, why, and name of doctor.)
○	○	B. Inability to perform certain motions	○	○	Have you ever had any illness or injury other than those already noted? (If yes, specify when, where and give details.)
○	○	C. Inability to assume certain positions	○	○	
○	○	D. Other medical reasons (If yes, give reasons)	○	○	Have you been treated by a physician within the past 5 years? (If yes, give complete name of doctor date, and reason.)
○	○	Have you ever worked with radioactive substance?	○	○	
○	○	Have you ever been refused employment because of your health? (If yes, stat reason and give details.)	○	○	Have you treated yourself for illness other than minor colds? (If yes, which illness?)

PRE-PLACEMENT EMPLOYEE PHYSICAL EXAMINATION
STUDENT EMPLOYEE HEALTH

○	○	Have you ever been denied life or health insurance? (If yes, state reason and give details.)	○	○	Have you ever been rejected for military service because of physical, mental, or other reasons? (If yes, give date and reason for rejection.)
○	○	Have you had, or have you been advised to have any operations? (If yes, describe and give age a which occurred.)	○	○	Is there any reason you cannot perform strenuous physical activity?
○	○	Will you be working with live animals? (If yes, what kind of animals?)	○	○	Will you perform CDC Category I surgery (i.e., cardiothoracic, orthopedic, OB-GYN, oral/maxillofacial or general surgery)?

Summary and elaboration of all significant data (indicate "yes" responses and describe.)

I certify that I have reviewed the foregoing information supplied by me and that it is true and complete to the best of my knowledge. I hereby consent and authorized my attending physician and/ or their designee to release any and a medical records or medical information arising from any of my prior medical examinations, to Student Employee Health, in order that a complete diagnosis of my condition may be had. I further consent to authorize Student Employee Health physicians and/or their designee to furnish my supervisors and/or their designee the results of their findings if such is pertinent to my employment or education.

Printed name	Signature

PPD Date _____ Result

PHYSICAL EXAMINATION (To be completed by physician)

✓ = Normal
X = Abnormal
O = Omitted

Wt.	Ht.	B.P.	Pulse	Temp.	
1.	General appearance				
2.	Hyper or hypoactive				
3.	Skin				
4.	Nails				
5.	Head	Scalp			
6.	Neck	Thyroid	Nodes	Vessels	
7.	Nose	Sinuses			
8.	Mouth	Tongue	Throat		
9.	Teeth				
10.	Ears	Drums			
11.	Eyes	Disc	Fundi	Vessels	
12.	Thorax				
13.	Lungs				
14.	Heart				
15.	Peripheral vessels				
16.	Abdomen				
17.	Rectum				
18.	Genitalia				
19.	Hernia				
20.	Extremities				
21.	Feet				
22.	Nerves				
23.	Back				
24.	Lymphatics				

Typed or printed name of physician or examiner	Date	Physician's signature	Number of attached sheets

Statement of your present health continued:

********** NOTICE TO SUPERVISOR **********

MEDICAL CENTER POLICY MANDATES THIS FORM BE COMPLETED AND RETURNED TO STUDENT/EMPLOYEE\HEALTH WITHIN TEN (10) DAYS OF EMPLOYMENT.

****

RISK OF EXPOSURE TO HEPATITIS B VIRUS
OR HUMAN IMMUNODEFICIENCY VIRUS
University of Mississippi Medical Center

DATE _____ UNIT/DEPT. _____

NAME _____ JOB TITLE _____

ID NUMBER _____ _____
SUPERVISOR'S SIGNATUIRE

A. This position involves the following work-related tasks:

	YES Routine Task	NO-But May Be Required	NO-Never Done
Bathes patients, including patients incontinent of urine and feces	( )	( )	( )
Examines patients including oral, rectal, vaginal, or wound examination	( )	( )	( )
Draws blood or gives medications using needle and syringe	( )	( )	( )
Performs or assists during invasive treatment of patients such as bronchoscopy, gastroscopy, insertion of central venous or arterial lines	( )	( )	( )
Performs surgery or scrubs during surgical procedures	( )	( )	( )
Applies dressings to post-op wounds or fresh lacerations	( )	( )	( )
Inserts, changes or empties drainage tubes	( )	( )	( )
Intubates patients or administers mouth-to-mouth resuscitation	( )	( )	( )
Cleans instruments and other medical devices contaminated by blood or body fluids	( )	( )	( )
Performs medical laboratory tests such as cultures, blood typing, and biopsies	( )	( )	( )
Picks up or processes biological waste or trash that may contain items contaminated by blood or body fluids	( )	( )	( )
Administers EEG or EMG tests using needle electrodes	( )	( )	( )
Performs research using human blood, body fluids, or tissues	( )	( )	( )
Performs or assists with autopsies	( )	( )	( )

Other job-related tasks that may involve exposure to blood, body fluids, or tissues (Specify)

_____ ( ) ( )

_____ ( ) ( )

B. The risk of exposure to Hepatitis B Virus or Human Immunodeficiency Virus in the performance of this job is classified as:(Check one only)

( ) CATEGORY I - The employee performs tasks that involve an inherent potential for mucous membrane or skin contact with blood, body fluids, tissues or a potential for spills or splashes. Universal precautions should be applied for all procedures or patient care when it is likely that the employee will have contact with blood or body fluids to prevent transmission of blood-borne pathogens.

( ) CATEGORY II - The employee performs tasks that involve no exposure to blood, body fluids, or tissues during the normal work routine, but the employee may be required to perform unplanned Category I tasks. Universal precautions should be used to perform any Category I procedures.

( ) CATEGORY III - The employee performs tasks that involve no exposure to blood, body fluids, or tissues during the normal work routine. No special precautions are necessary to prevent transmission of blood-borne pathogens.

Information about Hepatitis B vaccine (Recombinant)

The Disease

Hepatitis B is a viral infection caused by the hepatitis B virus (HBV) which causes death in 1-2% of patients. Most people with hepatitis B recover completely, but approximately 5-10% become chronic carriers of the virus. Most of these people have no symptoms, but can continue to transmit the disease to others. Some may develop chronic active hepatitis and cirrhosis. HBV also appears to be a causative factor in the development of liver cancer. Thus, immunization against hepatitis B can prevent acute hepatitis and also reduce sickness and death from chronic active hepatitis, cirrhosis and liver cancer.

The Vaccine

Hepatitis B vaccine is made using recombinant DNA technology with no serum from human donors. A high percentage of healthy people who receive three doses of vaccine achieve high levels of surface antibody (anti-HBs) and protection against hepatitis B. Full immunization requires 3 doses of vaccine over a six month period. There is no evidence that the vaccine has ever caused hepatitis B or AIDS. However, persons who have been infected with HBV prior to receiving the vaccine may go on to develop clinical hepatitis in spite of immunization. The duration of immunity is unknown at this time but is probably long term.

Possible Vaccine Side Effects

The incidence of side effects is very low. No serious side effects have been reported with the vaccine. A few persons experience tenderness and redness at the site of injection. Low grade fever may occur. Rash, nausea, joint pain and mild fatigue have also been reported. The possibility exists that more serious side effects may be identified in the future.

If you have any questions about hepatitis B or hepatitis B vaccine, please ask.

CONSENT FORM

I have read the above statement about hepatitis B and the hepatitis B vaccine. I have had an opportunity to ask questions and understand the benefits and risks of hepatitis B vaccination. I understand that I must have 3 doses of vaccine to confer immunity. However, there is no guarantee that I will become immune or that I will not experience an adverse side effect from the vaccine. I request that it be given to me or the person named below of whom I am the parent or guardian.

		Date Vaccinated	Lot #
Print Name of Person to Receive Vaccine	Date Signed	(1)	
		(2)	
Signature of Person Receiving Vaccine or Parent/Guardian		(3)	

Address	City	State	Zip Code

Social Security Number	Date of Birth	Employee # or Student Status

---

DECLINATION FORM

( ) No, I do not want to receive hepatitis B vaccine. I have been given the opportunity to be vaccinated with hepatitis B vaccine at no charge to myself. However, I decline hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series at no charge to me.

( ) No, I have completed the Hepatitis B vaccine series.

Signature of Employee	Date Signed	Printed Name of Employee

File: Employee Health Record

Revised 7/02