HELPING HANDS
HOMEMAKING SERVICES FOR CHRONICALLY ILL, INC.
Nassau (516) 489-6810 Suffolk (631) 261-0403
Fax (631) 261-3083

MEDICAL FORM

Name_____ Date of Birth: _____

Address:_____ Telephone: ( ) _____

I consent to this examination and release of information:
Signature:_____ Date:_____

. . . . . .

To be completed by physician only *Note to physician:*
In making your medical evaluation of the above patient, please be aware that he/she will be employed as a health care provider, which may involve homemaking and/or patient care. We are interested in this person's ability to function in this capacity.

PHYSICAL EXAMINATION:	NORMAL	ABNORMAL	Comment, if Abnormal:
Height:_____	EYES:		
	EARS:		
Weight:_____	NOSE:		
Blood Pressure:_____	THROAT:		
	LUNGS:		
Pulse:_____	HEART:		
Respiration:_____	BACK:		

LABORATORY TESTS:

RUBELLA	Date of Titre/Titre #:	OR	Date of Vaccine:
MEASLES (If born after 1/1/1957)	Date of Titre/Titre #:	OR	Date of Vaccine:
TUBERCULOSIS (within past 3 months)	PPD or Quantiferon Gold Date/Results:	OR	TB Screen or Chest X-ray: Date/Results:

DRUG SCREEN Date NEG POSITIVE (attach report)

FLU VACCINE Date COVID-19 VACCINE Date #1 Date #2

If the above named patient has any neurological disabilities, such as epilepsy, dizziness, paralysis, etc. please indicate type and degree of disability._____

I certify that the above named person is free from habituation or addiction to depressants, stimulants, narcotics, alcohol, or other drugs or substances which may alter the individual's behavior AND is free of any infectious diseases and in my opinion:

_____***Has NO restrictions or Has the following restrictions:***_____

Physician's signature: _____ **Physician's stamp:**

Date of examination: _____