STUDENT / INTERN
On-Boarding Packet

Welcome to AVALA! Attached are forms that must be completed to ensure your position here at AVALA is successful and fulfilling. Once the forms are completed, please return to Human Resources.

- Center of Excellence
- Student / Intern Data
- Policy & Procedures Acknowledgment
- HIPAA Security and Confidentiality Acknowledgment
- Anti-Harassment Policy and Acknowledgment
- Illegal Substance Abuse Policy and Acknowledgment Form
- Employment Status Acknowledgment
- Observer Forms [to be completed by Observers only]
- Covered Individual Health Requirements
- Tuberculosis PPD Testing
- Louisiana Worker's Compensation Post Hire Questionnaire

You will be required to have a TB skin test performed and read prior to your first day of duties. If you have had a TB skin test in the past 12 months, please bring documentation with you prior to your first day.

Covered Individuals includes all employees, volunteers, contract candidates, students, interns observers and vendors.

main: 985 809 9888 > www.avala.com > 67252 industry lane > covington, la 70433

CENTER OF EXCELLENCE

AVALA is proud to be certified as a Center of Excellence in Advanced Orthopedic & Spine by our accrediting body, DNV.

AVALA is committed to a comprehensive approach to improving healthcare quality and patient outcomes by aligning with our mission and vision, creating an environment that supports a dynamic, initiative-taking, and safe culture for patients, family members, visitors, and employees, through continuous learning and improving patient care policies, systems, and processes.

In support of our mission and vision, the program promotes:

- Collaboration of the healthcare team, leadership, medical staff, and other healthcare providers to deliver integrated and comprehensive high-quality healthcare.
- Communicate honestly and openly to foster trusting and cooperative relationships among healthcare providers, staff members, and patients and their families, to ensure accountability for the quality management priorities.
- A focus on continuous learning and improving, system design, and the management of processes and changes, bringing the best possible outcomes for patients.
- Incorporation of evidence-based practice guidelines and standards to deliver high quality, safe healthcare.
- Education of staff, physicians, and contracted services to assure participation and continuous learning of healthcare providers.

As part of the Advanced Orthopedic and Spine Certification, students / volunteers / contracted services must also possess adaptability to processes as related to up-to-date best practices, collaboration between departments, compliance with protocols/processes, communication, cooperation and exceptional customer service.

STUDENT / INTERN DATA

Name:

_____

First MI Last

Current Address: _____

City/State/Zip: _____

Email Address:_____

Home Phone #:_____

Cell Phone#:_____

Emergency Contact Information: (someone we should contact in case of an emergency)

Name:_____

Relationship:_____

Phone number:_____

Address:_____

City:_____State:_____Zip:_____

Signature _____ Date _____

Acknowledgment

I, _____, (print) agree to follow all of AVALA's policies and procedures including those outlined in this packet.

_____
Signature

_____
Date

CONFIDENTIALTY STATEMENT

I, _____, agree to adhere to the Confidentiality Policy of AVALA, which states that all information regarding employees, patients, contractors, customers and others with whom there is a business agreement or fiduciary relationship is private, confidential and privileged in accordance with State and Federal laws, rules, regulations and/or statutes. The term information is understood to include, but is not limited to, verbal, electronic, telephonic and written information such as documents, compensation, records, medical records, discussions, recorded messages, photos, video tapes or any other type of information or communication. I agree not to take any voluntary disclosure of any such confidential information obtained in the course of my employment to any unauthorized individual or agency. I recognize that if I voluntarily divulge or release such confidential information without expressed permission from an authorized individual, I may be subject to civil action under the provisions Federal and / or State Statutes. Additionally, breech of this confidentiality statement shall be cause for termination of my employment or status at AVALA.

Printed Name: _____

Signature:_____

Date: _____

HIPAA SECURITY AND CONFIDENTIALITY AGREEMENT

As a Covered Individual, as described on page 1, I agree to the following:

1. I understand that I am responsible for complying with the HIPAA policies and procedures, which were provided to me.

2. I will treat all information received in the course of my role with AVALA, which relates to the patients seen at this facility, as confidential and privileged information.

3. I will not access patient information unless I have a need to know this information in order to perform my job.

4. I will not disclose information regarding patients to any person or entity, other than as necessary to perform my job, and as permitted under the HIPAA Policies.

5. I will not log on to any of the AVALA computer systems that currently exist or may exist in the future using a password other than my own.

6. If applicable, I will safeguard my computer password and will not post it in a public place, such as the computer monitor or a place where it will be easily lost, such as on my security ID badge.

7. I will not allow anyone, including other employees, to use my password to log on to the computer.

8. I will log off of the computer as soon as I have finished using it.

9. I will not use e-mail to transmit patient information unless I am instructed to do so by the Privacy Officer.

10. I will not take patient information from the premises in paper or electronic form without first receiving permission from the Privacy/Compliance Officer.

11. Upon conclusion of my tenure, I agree to continue to maintain the confidentiality of any information I learned while at AVALA and agree to return any keys, access cards, or any other device that would provide access to the facility or its information.

I understand that violation of this agreement could result in disciplinary actions. I hereby acknowledge that I have been informed of the HIPAA policies and procedures of AVALA. I understand that I am responsible for complying with the policies and procedures and that I am required to seek guidance from the Compliance Officer if I have any questions or concerns regarding HIPAA.

_____ _____

Name (print) Date

_____

Name (signature)

ANTI HARASSMENT AND ANTI DISCRIMINATION

It is the intention of AVALA to promote a pleasant work environment in which all individuals are treated with respect and dignity. Each individual has the right to work in a professional atmosphere which promotes equal opportunities and prohibits discriminatory practices, including harassment on the basis of race, color, religion, sex, sexual orientation, gender identity or expression, age, disability, marital status, citizenship, national origin, genetic information, or any other characteristic protected by law. AVALA prohibits any such discrimination or harassment. Employees who engage in discrimination, harassment and/or retaliation may be subject to disciplinary action including but not limited to termination of employment or status. AVALA expects all relationships among staff to be professional and businesslike and free of bias, prejudice, and harassment. Any employee who has questions regarding these policies should speak with HR.

HARASSMENT DEFINED: The Equal Employment Opportunity Commission defines harassment as unwanted physical, verbal or visual sexual advances, request for favors, and other sexually oriented conduct offensive or objectionable to the recipient, including, but not limited to: epithets, derogatory or suggestive comments, slurs or gestures, and offensive poster, cartoons, pictures, or drawings.

REPORTING: Covered Individuals experiencing discrimination and / or harassment should make a report with HR, Management, any member of Leadership or whomever said individual is comfortable speaking with. It is the responsibility of each Covered Individual of AVALA to report any complaints he/she receives from any individual to a member of HR, management, or leadership. Issues or complaints regarding discrimination or harassment should be reported as soon as possible. Covered Individuals should not feel obligated to file their complaints with their immediate department managers. Complaints must be made in writing.

INVESTIGATION PROCESS: All complaints of discrimination and / or harassment will be investigated promptly and with due regard for impartiality and confidentiality. The investigation may include an interview with the parties involved. When applicable, it may be necessary to interview individuals who may have witnessed the discrimination and / or harassment. AVALA will attempt to always maintain confidentiality throughout the investigation unless disclosure of information is needed to complete the investigation or if requested by legal counsel or law enforcement. Results of the finding will be discussed with the accuser if the accuser is still employed by AVALA. Should the accuser not be employed by or associated with AVALA, results of the investigation may not be shared with the former covered individual. Any person who is found to have engaged in discrimination, harassment and / or retaliation will be subject to discipline, up to and including termination of status. If the complaint involves a non-employee of AVALA, such as a patient or vendor, management will take appropriate steps to end the discrimination and / or harassment.

AVALA recognizes that false accusations of harassment can have serious effects on innocent persons. If an investigation results in a finding that a person, who has accused another of discrimination and / or harassment, has maliciously or recklessly made false accusations, the accuser will be subject to appropriate sanctions, up to and including discharge or termination of employment.

RETALIATION: AVALA prohibits retaliation against an individual who reports harassment or discrimination or participates in an investigation of such reports. Any form of retaliation is a serious violation of policy and the covered individual may be subject to disciplinary action up to and including discharge or termination of employment.

I have read, understand and agree to abide by AVALA's Anti-Harassment and Discrimination Policy.

_____ _____

Signature Date

Illegal Substance Abuse

PURPOSE:

To ensure a safe and healthy environment for all on AVALA's campus.

To ensure that all covered individuals report to work in an appropriate mental and physical condition to perform their jobs in a satisfactory manner, free from the use of illegal or inappropriate medications or alcohol while at AVALA.

POLICY:

Covered Individuals may not use, possess, distribute, sell, or be under the influence of illegal drugs or alcohol while on the premises of AVALA. AVALA reserves the right under Louisiana Law, as a condition of employment or continuing employment, to request its employees to submit to drug or alcohol testing at any time.

Refusal to submit to drug or alcohol testing may be considered grounds for immediate termination of employment or status.

The legal use of prescribed drugs by a licensed physician is permitted on the job if it does not impair a Covered Individual's ability to perform the essential functions of his/her job effectively and in a safe manner that does not endanger themselves or other individuals in the workplace. Covered Individual's are required to give notification of the specific medication, date of prescription and the prescribing physician to their supervisor. All information will be held in confidence, to the extent possible and practicable. Such information will be disseminated only if required by court or governmental agency to the extent necessary to ensure safety of the employee, co-workers, or the public.

Random drug or alcohol screening may be administered under the following conditions: reasonable suspicion, when an employee shows signs of impairment; after any accident or occurrence that results in an injury on the job; after a vehicular accident. Covered Individuals are required to report to the designated location immediately for testing. Failure to report to the specified location in the appropriate time frame may result in immediate termination.

As a condition of employment, all new hires are required to pass the pre-employment drug screening.

On occasion, for office-related events, administration may approve the consumption of alcoholic beverages on the premises of AVALA. Covered Individuals must be off duty to participate in such events. During these events, Covered Individuals are expected to conduct themselves in a responsible and prudent manner.

Any violation of this policy may lead to disciplinary action, up to and including immediate termination of employment or status, and/or required participation in a substance abuse rehabilitation/treatment program. Such violations may also result in legal consequences, such as the disqualification of benefits under the Louisiana Workman's Compensation Act and the Louisiana Unemployment Compensation Act.

RESPONSIBILITY:

It is the responsibility of each Covered Individual to ensure that he/she adheres to the policy.

_____ _____

Signature Date

Employment or Non-Employment Status Acknowledgment

___Student/Intern:

I understand that I have been scheduled to work as a volunteer/contract candidate/student/intern/observer / vendor and I will receive no compensation during this period. I understand that I am not eligible for employee benefits (e.g. medical, dental, vision, FSA, and employer paid LTD and Basic Life Insurance, etc.) unless required by state and federal law. I also understand that I am not eligible to participate in the 401K retirement plan.

_____ _____

Name Signature

_____

Date

This form is to only be completed by Anesthesia students.

All forms must be completed and returned to Human Resources at least three (3) days prior to observation.

I understand that on my scheduled day(s), I will await instructions from the Anesthesia Lead or Director.

_____ _____

Name Date

Statement of Agreement

Anesthesia Student

1.) I understand that I am to consider all information regarding patient care and welfare, including the presence of the patient in the hospital as privileged and confidential.

2.) I commit to protecting the privacy of the patients at AVALA, and I will not divulge, release or share information which is confidential with any other individuals or entities.

3.) I am aware of the rights of the patient, as distributed and posted in the “Patient Rights and Responsibilities” and will exercise these rights without regard to race, color, religion, sex, sexual orientation, gender identity, or expression, age, disability, marital status, citizenship, national origin, genetic information, culture, economic, educational or religious background or any other characteristic protected by law.

4.) I recognize that our patient population and workforce are comprised of a wide variety of perspectives, viewpoints and backgrounds encompassing cultural diversity.

5.) At the time of executing this Agreement, I declare that I am free from any infectious diseases and have no symptoms or concerns which could be of an infectious nature. I understand that when entering AVALA, I must be free of any infectious diseases, and I agree that I will not enter AVALA if I have any symptoms or concerns which may or could be of an infectious nature.

6.) I understand that I must show proof of a TB skin test that has been administered in the last 12 months, or if not available, I agree to be given a new one, which must be completed and read prior to my first day.

7.) I understand that transmission of infection is linked to lack of adherence to handwashing guidelines. I agree to be compliant with the handwashing guidelines, consisting of washing hands before and after any patient contact or contact with objects in the immediate vicinity of the patient following universal precautions.

8.) I agree and acknowledge that I am in AVALA at my own risk, and release AVALA from any liability or claims related to my presence in the facility. I further agree to indemnify AVALA from any and all liability, loss or damage AVALA may suffer as a result of any claims, demands, or costs which may be asserted against AVALA arising from my presence in the facility.

9.) I agree and acknowledge that I will be under the supervision of the individual with authority for the area in the facility wherein I am located. Any adverse patient event will be reported to the supervising authority. I will abide by and comply with all the directives given me by such individual.

10.) Name tags are required while in the facility. If you do not have a name tag, a temporary tag will be provided at the registration desk.

11.) I understand that a requirement of being allowed in the surgical field and / or if I am within one foot of the surgical field, I must be gowned and gloved in a sterile manner to protect against contamination.

OSignature _____ Date/Time_____

AVALA®

STUDENT HEALTH ASSESSMENT

STUDENT INFORMATION

NAME: _____ DATE: _____

DATE OF BIRTH: _____ GENDER: ☐ MALE ☐ FEMALE

HOME ADDRESS: _____

_____

TELEPHONE: _____

COVERED INDIVIDUALS' HEALTH REQUIREMENTS

(ONLY COMPLETE IF APPLICABLE)

COVERED INDIVIDUALS INCLUDES ANY INDIVIDUAL WHO WILL BE IN ONE OF THE FOLLOWING ROLES: EMPLOYEE / SHADOWING / STUDENT / VOLUNTEER / OBSERVER / CONTRACT ON AN AVALA CAMPUS. COVERED INDIVIDUALS WILL BE REQUIRED TO SHOW PROOF OF A CURRENT TB SKIN TEST. IF UNABLE TO PROVIDE PROOF OF A CURRENT TB TEST, THE INDIVIDUAL MAY BE REQUIRED TO WEAR A MASK THE ENTIRE TIME THEY ARE ON AN AVALA CAMPUS.

BY SIGNING BELOW, I ACKNOWLEDGE THAT I WILL NOT BE ALLOWED TO BEGIN MY ROLE WITH AVALA UNTIL I HAVE COMPLETED THE TB TEST REQUIREMENT AND COMPLETED THE FORMS ON THE FOLLOWING PAGES. ALL HEALTH ASSESSMENT INFORMATION WILL BE SUBMITTED TO THE EMPLOYEE HEALTH NURSE.

ACKNOWLEDGEMENT

_____	_____	_____
STUDENT SIGNATURE	PRINTED NAME	DATE

_____	_____
EMPLOYEE HEALTH NURSE	DATE

COVERED INDIVIDUALS' HEALTH REQUIREMENTS

ALL COVERED INDIVIDUALS MUST MEET WITH THE EMPLOYEE HEALTH NURSE BEFORE THEIR 1ST SHIFT/DAY.

ALL HEALTH-RELATED FORMS WILL BE COMPLETED AT THIS TIME, INCLUDING THE HEALTH ASSESSMENT, TUBERCULOSIS, AND THE N95 MASK FIT SCREENING.

ONE (1) TB TEST WILL BE ADMINISTERED AT THE TIME OF THE APPOINTMENT, WITH FOLLOW-UP IN 48-72 HOURS.

PLEASE BRING ANY PRIOR IMMUNIZATION RECORDS WITH YOU. ALSO, AVALA REQUIRES A TB TEST IF THE PRIOR TEST IS OVER 12 MONTHS OLD.

PLEASE CALL THE EMPLOYEE HEALTH NURSE TO SET UP AN APPOINTMENT. THIS SHOULD TAKE NO LONGER THAN 15 MINUTES.

WELCOME ABOARD!

STACY DUFOUR, BSN, RN, CIC
EMPLOYEE HEALTH NURSE
985-801-2035

OFFICE HOURS
MONDAY - FRIDAY
7:30 AM - 3:30 PM

ACKNOWLEDGEMENT

BY SIGNING BELOW, I ACKNOWLEDGE THAT I WILL NOT BE ALLOWED TO BEGIN ORIENTATION OR WORK A SHIFT UNTIL I HAVE COMPLETED THE ABOVE REQUIREMENTS WITH THE EMPLOYEE HEALTH NURSE.

STUDENT SIGNATURE	PRINTED NAME	DATE

IMMUNIZATIONS

THE FOLLOWING IMMUNIZATIONS AND SCREENING TESTS ARE RECOMMENDED BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) FOR ALL HEALTHCARE WORKERS. PLEASE COMPLETE THIS ATTESTATION, SIGN, DATE, AND RETURN TO THE EMPLOYEE HEALTH NURSE.

PRINTED NAME _____ DATE _____

1. INFLUENZA

ANNUAL INFLUENZA VACCINATION IS HIGHLY RECOMMENDED DUE OF ANTIGENIC SHIFTS. IT IS OFFERED ANNUALLY, FREE OF CHARGE TO EMPLOYEES. VACCINATION HAS BEEN SHOWN TO REDUCE THE SPREAD OF INFLUENZA TO PATIENTS AND FAMILY MEMBERS. (SELECT ONE)

☐ I UNDERSTAND THE NEED TO BE VACCINATED FOR INFLUENZA EACH FLU SEASON.

☐ I HAVE BEEN VACCINATED FOR INFLUENZA ELSEWHERE (DOCUMENTATION REQUIRED).

☐ I HAVE A CONTRAINDICATION TO RECEIVING THE INFLUENZA VACCINE (DOCUMENTATION REQUIRED).

☐ I DECLINE THE INFLUENZA VACCINE AND UNDERSTAND THAT DOING SO MAY PUT ME AT RISK OF ACQUIRING AN INFLUENZA INFECTION. ADDITIONALLY, IT MAY INCREASE THE RISK OF ME (ASYMPTOMATICALLY) SPREADING INFLUENZA TO PATIENTS, COWORKERS, AND FAMILY. ACCORDINGLY, I UNDERSTAND THAT FOR INFECTION CONTROL PURPOSES, I MAY BE ASKED TO WEAR A MASK IN PATIENT CARE AREAS DEPENDING UPON SEASONAL RISK ASSESSMENT AND CDC RECOMMENDATIONS.

2. TDAP

TETANUS, DIPHTHERIA, AND ACELLULAR PERTUSSIS VACCINE WERE RECOMMENDED IN 2006 FOR HEALTHCARE PERSONNEL IN RESPONSE TO AN EPIDEMIC OF ADULT PERTUSSIS. PERTUSSIS PRESENTLY ACCOUNTS FOR UP TO 25% OF CHRONIC COUGH IN SOME ADULT POPULATIONS AND CAN BE LETHAL TO INFANTS. AT THE PRESENT TIME, IT IS SUGGESTED THAT THE VACCINE BE TAKEN ONCE BUT WILL MOST LIKELY BECOME THE VACCINE OF CHOICE EVERY TEN YEARS, REPLACING THE OLD TD (TETANUS/ADULT DIPHTHERIA) INJECTION. VACCINATION WITH TDAP SHOULD BE DELAYED IF YOU HAVE RECEIVED A TETANUS IMMUNIZATION WITHIN THE LAST 2 YEARS (TO AVOID ARTHUS REACTIONS). IT IS NOT RECOMMENDED FOR PREGNANT WOMEN DUE TO POSSIBLE INTERFERENCE WITH LATER NEONATE RESPONSE TO IMMUNIZATIONS. (SELECT ONE)

☐ I HAVE RECEIVED THE TDAP VACCINE.

☐ I HAVE NOT RECEIVED THE TDAP VACCINE. I UNDERSTAND THAT HEALTHCARE PERSONNEL WHO HAVE NOT RECEIVED THIS VACCINATION WILL HAVE TO WEAR A SURGICAL MASK WHEN PROVIDING CARE TO INFANTS LESS THAN 12 MONTHS OF AGE.

3. VARICELLA

A PAST HISTORY OF CHICKEN POX OR SHINGLES IS ACCEPTABLE EVIDENCE OF IMMUNITY. IF YOU ARE UNSURE, A VARICELLA TITER CAN BE DRAWN. TWO VARICELLA VACCINATIONS ARE NOW RECOMMENDED FOR ADULTS WHO HAVE NOT HAD THE DISEASE. RECENT DATA INDICATE THAT AT LEAST 10% OF SINGLE-INJECTION RECIPIENTS OF THE VARICELLA VACCINE ARE AT RISK FOR DEVELOPING "BREAK-THROUGH" DISEASE. THE VACCINE IS LIVE AND NOT RECOMMENDED FOR PREGNANT WOMEN. (SELECT ONE)

☐ I HAVE HAD NATURAL VARICELLA DISEASE.

☐ I HAVE HAD VARICELLA VACCINATION.

☐ I HAVE SEROLOGIC DOCUMENTATION OF IMMUNITY TO VARICELLA.

☐ I HAVE NOT BEEN VACCINATED / I DO NOT KNOW MY VACCINATION STATUS.

4. HEPATITIS B

THE CDC AND OSHA RECOMMEND ENSURING HEPATITIS B IMMUNITY FOR ALL HEALTHCARE WORKERS FOR WHOM EXPOSURE TO BLOOD / BODY FLUIDS IS REASONABLY ANTICIPATED. THIS DESIGNATION APPLIES TO MOST CLINICAL EMPLOYEES, ESPECIALLY IN HIGH-EXPOSURE AREAS, SUCH AS THE OPERATING ROOMS. IF YOU HAVE NOT BEEN VACCINATED FOR HEPATITIS B, WE OFFER THE VACCINATION AT NO COST TO YOU. IF YOU ARE UNSURE ABOUT YOUR IMMUNITY, WE CAN PERFORM A SEROLOGIC TITER. (SELECT ONE)

☐ I HAVE ALREADY RECEIVED (3 OR 4 SERIES) VACCINATION FOR HEPATITIS B.

☐ I HAVE NOT RECEIVED A COMPLETE VACCINATION SERIES FOR HEPATITIS B.

☐ I UNDERSTAND THAT MY JOB MAY INVOLVE OCCUPATIONAL EXPOSURE TO BLOOD OR OTHER INFECTIOUS MATERIALS THAT PUT ME AT RISK FOR HEPATITIS B (VIRAL) INFECTION. I HAVE BEEN ALLOWED TO BE VACCINATED AGAINST HEPATITIS B AT NO CHARGE TO MYSELF, BUT I AM DECLINING AT THIS TIME. I UNDERSTAND THAT BY DECLINING, I REMAIN AT RISK OF ACQUIRING HEPATITIS B.

5. MMR

TWO MMR VACCINATIONS AFTER ONE YEAR OF AGE ARE RECOMMENDED BY THE CDC FOR HEALTHCARE PERSONNEL. HEALTHCARE PERSONNEL BORN BEFORE 1957 WHO ARE UNVACCINATED AND LACK LABORATORY EVIDENCE OF MEASLES, MUMPS, AND RUBELLA IMMUNITY SHOULD CONSIDER VACCINATION. THIS IS A LIVE VACCINE CONTRAINDICATED IN PREGNANCY, IMMUNOCOMPROMISED PATIENTS, RECENT RECIPIENTS OF IMMUNE GLOBULIN, AND THOSE WHO'VE HAD ANAPHYLAXIS TO GELATIN OR NEOMYCIN. (SELECT ONE)

☐ I WAS BORN BEFORE 1957.

☐ I HAVE SEROLOGIC EVIDENCE OF PROTECTIVE ANTIBODIES TO ALL THREE DISEASES.

☐ I HAVE RECEIVED TWO MMR VACCINATIONS.

☐ I HAVE NOT BEEN VACCINATED / DO NOT KNOW MY VACCINATION STATUS.

6. TUBERCULOSIS SCREENING

IF YOU'VE HAD A TB TEST WITHIN THE PREVIOUS 12 MONTHS, WE WILL ACCEPT THAT TEST – DOCUMENTATION IS REQUIRED. IF NEGATIVE, SUBSEQUENT ASSESSMENTS ARE VIA AN ANNUAL SCREENING QUESTIONNAIRE. IF YOU HAVE NOT HAD A TB TEST WITHIN THE LAST 12 MONTHS, WE REQUIRE ONE SKIN TEST BEFORE YOUR START DATE. (SELECT ONE)

☐ I HAVE TESTED NEGATIVE FOR TUBERCULOSIS WITHIN THE PAST YEAR (DOCUMENTATION REQUIRED).

☐ I HAVE HAD A POSITIVE TST (TUBERCULIN SKIN TEST) IN THE PAST AND HAVE HAD NEGATIVE FOLLOW-UP CHEST X-RAYS (DOCUMENTATION REQUIRED).

☐ I HAVE BEEN TREATED FOR TB IN ACCORDANCE WITH CDC GUIDELINES BUT CURRENTLY HAVE NO ACTIVE DISEASE (DOCUMENTATION REQUIRED).

☐ OTHER: _____

ACKNOWLEDGEMENT

I ATTEST THAT THE ABOVE INFORMATION IS ACCURATE AND THAT I UNDERSTAND IT IS MY RESPONSIBILITY TO MEET ALL APPLICABLE VACCINATION AND TESTING REQUIREMENTS FOR HOSPITAL-BASED HEALTHCARE WORKERS.

STUDENT SIGNATURE	PRINTED NAME	DATE

WITNESS NAME

AVALA®

STUDENT HEALTH ASSESSMENT

PERSONAL HEALTH HISTORY

PLEASE CHECK THE APPROPRIATE BOX – EVERY CONDITION/ILLNESS/INJURY REQUIRES A YES OR NO ANSWER. FOR ALL CONDITIONS BELOW THAT YOU CHECK YES, PLEASE WRITE A BRIEF EXPLANATION ON THE EXPLANATION PAGE.

YES	NO	CONDITION
		ANXIETY
		ARTHRITIS
		ASTHMA
		BLEEDING DISORDERS
		BLOOD CLOTS
		BLOOD PRESSURE HIGH/LOW
		BREATHING DISORDERS
		CANCER
		CEREBRAL PALSY
		CHRONIC COUGH
		DEMENTIA
		DEPRESSION
		DIABETES
		EPILEPSY/SEIZURES
		FAINTING SPELLS
		GI DISORDERS
		HEARING LOSS
		HEART ATTACK
		HEART DISORDERS

YES	NO	CONDITION
		HERNIA
		HIV/AIDS
		INJURY – BACK/SPINE
		INJURY – HEAD
		INJURY – JOINT
		INJURY – NECK
		INJURY – OTHER
		KIDNEY DISORDERS
		LOSS OF LIMB
		MENTAL DISORDERS
		MIGRAINES
		MULTIPLE SCLEROSIS
		MUSCULAR DYSTROPHY
		ORGAN TRANSPLANT
		RHEUMATISM
		SCOLIOSIS
		SKIN CONDITIONS
		VISION LOSS
		OTHER (EXPLAIN BELOW):

DATE	SURGICAL PROCEDURE

EXPLANATION PAGE

CONDITION: _____ **YEAR DIAGNOSED (APPROX):** _____

ARE YOU STILL TREATING FOR THIS CONDITION? ☐ YES ☐ NO

ARE YOU TAKING MEDICATION FOR THIS CONDITION? ☐ YES ☐ NO

DO YOU HAVE ANY PERMANENT RESTRICTIONS FOR THIS CONDITION? ☐ YES ☐ NO

BRIEF EXPLANATION: _____

AVALA®

STUDENT HEALTH ASSESSMENT

CONDITION: ______________________ **YEAR DIAGNOSED (APPROX):** __________

ARE YOU STILL TREATING FOR THIS CONDITION? ☐ YES ☐ NO

ARE YOU TAKING MEDICATION FOR THIS CONDITION? ☐ YES ☐ NO

DO YOU HAVE ANY PERMANENT RESTRICTIONS FOR THIS CONDITION? ☐ YES ☐ NO

BRIEF EXPLANATION: ______________________________

CONDITION: ______________________ **YEAR DIAGNOSED (APPROX):** __________

ARE YOU STILL TREATING FOR THIS CONDITION? ☐ YES ☐ NO

ARE YOU TAKING MEDICATION FOR THIS CONDITION? ☐ YES ☐ NO

DO YOU HAVE ANY PERMANENT RESTRICTIONS FOR THIS CONDITION? ☐ YES ☐ NO

BRIEF EXPLANATION: ______________________________

CONDITION: ______________________ **YEAR DIAGNOSED (APPROX):** __________

ARE YOU STILL TREATING FOR THIS CONDITION? ☐ YES ☐ NO

ARE YOU TAKING MEDICATION FOR THIS CONDITION? ☐ YES ☐ NO

DO YOU HAVE ANY PERMANENT RESTRICTIONS FOR THIS CONDITION? ☐ YES ☐ NO

BRIEF EXPLANATION: ______________________________

CONDITION: ______________________ **YEAR DIAGNOSED (APPROX):** __________

ARE YOU STILL TREATING FOR THIS CONDITION? ☐ YES ☐ NO

ARE YOU TAKING MEDICATION FOR THIS CONDITION? ☐ YES ☐ NO

DO YOU HAVE ANY PERMANENT RESTRICTIONS FOR THIS CONDITION? ☐ YES ☐ NO

BRIEF EXPLANATION: ______________________________

HAS THE DOCTOR EVER RESTRICTED YOUR ACTIVITIES? ☐ YES ☐ NO

IF YES, PLEASE LIST RESTRICTION DETAILS: ______________________________

WERE RESTRICTIONS: ☐ PERMANENT ☐ TEMPORARY

ARE YOUR ACTIVITIES CURRENTLY RESTRICTED? ☐ YES ☐ NO

WHAT IS THE MEDICAL CONDITION FOR WHICH YOU CURRENTLY HAVE RESTRICTIONS? ______________

ARE YOU PRESENTLY BEING TREATED BY A DOCTOR, CHIROPRACTOR, PSYCHIATRIST, PSYCHOLOGIST, OR OTHER HEALTHCARE PROVIDER? ☐ YES ☐ NO

HEALTHCARE NAME: ______________________________

SPECIALITY: ______________________________

IF YOU ARE TAKING ANY PRESCRIPTION MEDICATION(S) NOT PREVIOUSLY MENTIONED ON THE EXPLANATION PAGE, PLEASE LIST BELOW:

____

____

TB QUESTIONNAIRE

YES	NO	SIGNS/SYMPTOMS ASSOCIATED WITH ACTIVE TB
		PRODUCTIVE COUGH LASTING 3 WEEKS OR LONGER
		UNEXPECTED WEIGHT LOSS
		UNEXPLAINED PERSISTENT LOW-GRADE FEVER
		UNEXPLAINED NIGHT SWEAT
		CHILLS
		UNEXPLAINED LOSS OF APPETITE
		COUGHING UP BLOOD
		HAVE YOU EVER RECEIVED THE BCG VACCINE?
		PREVIOUS POSITIVE TB SKIN TEST/BLOOD TEST (QUANT GOLD/T-SPOT)
		ABNORMAL CHEST X-RAY
		IF YES – DATE OF POSITIVE TEST:
		HAVE YOU TAKEN INH, RIFAMPIN, PYRAZINAMIDE, AND/OR ETHAMBUTOL
		TREATMENT COMPLETED?

ACKNOWLEDGEMENT

I ATTEST THAT THE ABOVE INFORMATION IS COMPLETE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

STUDENT SIGNATURE	PRINTED NAME	DATE

EMPLOYEE HEALTH REPRESENTATIVE	DATE