Del Mar union school district
11232 El Camino Real, San Diego, CA 92130 – Ph: (858) 755-9301- Fax: (858) 523-6114

PRE-EMPLOYMENT PHYSICAL INFORMATION

The following facility is approved for pre-placement medical examinations.

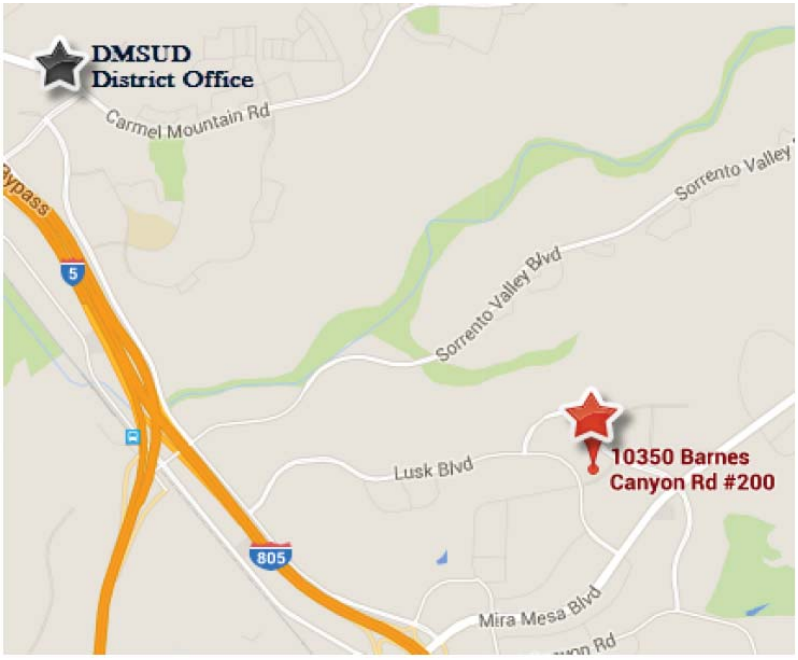
U.S. HealthWorks™

10350 Barnes Canyon Rd, Ste 200
San Diego, CA 92121

Phone: (858) 455-0200
Fax: (858) 455-0044

Centrally located on Barnes Canyon Rd between Lusk Blvd and Pacific Heights Blvd.

Physical Examinations:
Monday - Friday
8:00am - 5:00pm



PRE-PLACEMENT PHYSICAL APPOINTMENT INFORMATION

Name: _____
Position: _____
Appointment Date: _____
Time: _____
District: DEL MAR UNION SCHOOL DISTRICT
Signed-District Personnel Alicia Laube

Please mark the box of the group number of the test you want performed and/or indicate on the line below any optional test that you would like done.

☐ Group I

Physical Examination includes:

-Medical History
-Occupational History
-Height
-Weight
-Blood Pressure
-Vision Test (color, near, far)
-Physical Examination Interpretation
-Non-DOT drug screen (includes MRO service)
-TB skin test (AT EMPLOYEE'S EXPENSE, IF NEEDED.)

☒ Group II

Physical Examination includes:

-Medical History
-Occupational History
-Height
-Weight
-Blood Pressure
-Vision Test (color, near, far)
-Physical Examination Interpretation
-Non-DOT drug screen (includes MRO service)
-TB skin test (AT EMPLOYEE'S EXPENSE, IF NEEDED.)
-Physical Abilities Test:
◉ 50 lbs ○ 75 lbs

NO DRESSES/SKIRTS
NO FLIP FLOPS

☐ Group III
Bus Drivers

Physical Examination Includes:
-Medical History
-Occupational History
-Height
-Weight
-Blood Pressure
-Vision Test (color, near, far)
-Whisper Test
-Urinalysis (glucose and protein) *Required by the state*
-Physical Examination Interpretation
-Completion of DMV paperwork
-DOT drug screen collection only
-TB skin test
-Physical Abilities Test

Remember:

- Please be on time.
- If you are having a physical ability test, please wear comfortable clothes and comfortable closed toe shoes.
- Bring your driver's license or picture ID.
- Bring your completed health history questionnaire, this appointment notice and signed consent.
- If you are unable to keep this appointment, it is your responsibility to notify the clinic and the School District.
- DO NOT BRING CHILDREN

U.S. HealthWorks MEDICAL GROUP
The Right Care, Right Away

ePassport

CID2817842

Applicant / Donor Information

Please present this information sheet to the clinic listed below for drug screen collection services:

US Healthworks-Sorrento Mesa
5897 Oberlin Dr., STE 100
San Diego, CA 92121

Clinic Phone : 858-455-0200
Fax: 858-455-0044

- ☐ Follow-up
- ☒ Pre-employment
- ☐ Reasonable suspicion/cause
- ☐ Post-accident
- ☐ Return-to-duty
- ☐ Transfer
- ☐ Random
- ☐ Periodic Medical
- ☐ Promotion
- ☐ Other

Services to be performed:

eCup

DON'T FORGET!

- Take ePassport and Photo ID
- All other documents provided by employer
- Call clinic to confirm their hours of service

Clinic Information

This is to introduce _____ from Del Mar Union School District for an eScreen drug screen collection. Please scan the above barcode to pull up the correct client account. Specific Account information for this donor is as follows:

Del Mar Union School District
eScreen Account #: 107854-19
11232 El Camino Real
San Diego , CA 92130

Instructions

Please use standard lab-based collection procedures using the chain of custody form presented by the donor.
If you have any problems performing a standard collection please contact eScreen at (800) 881-0722, opt 5.

eScreen, Inc.
Attention: Accounts Payable
PO Box 25902
Overland Park, KS 66225-5902

(800) 881-0722

2-Hole 1/4 2 3/4 c-to-c

U.S. HealthWorks MEDICAL GROUP

INT

EMPLOYER SERVICES INTAKE INFORMATION

CLOCK IN ARRIVAL

CLOCK IN COMPLETION FORMS

PATIENT NAME *(Nombre del Paciente)*:_____ AGE *(Edad)*:_____

ADDRESS *(Dirección)*:_____

CITY *(Ciudad)*:_____ STATE (*Estado)*:_____ ZIP:_____

SOCIAL SECURITY *(SS#)*:_____ DATE OF BIRTH *(Fecha de Nacimiento)*:_____ SEX*(o)*: ❒ M ❒ F

TEL. CELL *(Celular):* ( ) _____ TEL. HOME *(Casa)*: ( ) _____

EMAIL ADDRESS *(Dirección de Correo Electrónico)*:_____

EMPLOYER NAME *(Empleador)*: DEL MAR UNION SCHOOL DISTRICT JOB POSITION (*Posición)* :_____

VISIT FOR *(Visita para)*: ☒ Pre-Placement Exam *(Exámen de Trabajo)* ☒ DRUG TEST *(Exámen de Drogas)* OTHER *(Otro)*: _____

FOR OFFICE USE ONLY / SOLO PARA USO DEL MEDICO

SERVICES:

❒ PHYSICAL EXAM _____

❒ MEDICAL SURVEILLANCE EXAM

VISION: ❒ Snellen ❒ Titmus

URINALYSIS: ❒ Dipstick ❒ Lab

❒ AUDIOGRAM ❒ PFT ❒ EKG

❒ BACK EVALUATION ❒ FCE/ PAT

❒ LAB TESTS:_____

❒ X-RAYS:_____

DRUG SCREEN: ❒ DOT ❒ Non-DOT ❒ Instant: Panel:____

ALCOHOL TEST: Breath: ❒ DOT ❒ Non-DOT ❒ Saliva

REPORTING INSTRUCTIONS:

❒ Return paperwork w/ employee

❒ Return paperwork by mail

❒ Fax report to: Attention:_____

Secure Number:_____

❒ Other:_____

OTHER SERVICES:

ADDITIONAL COMMENTS/ INSTRUCTIONS:

CLOCK OUT DISCHARGE

CLOCK IN FOR MA

2-Hole 1/4 2 3/4 c-to-c

U.S. HealthWorks™ MEDICAL GROUP

AUA

PATIENT CONSENT AND ACKNOWLEDGEMENT

CONSENT FOR EVALUATION AND TREATMENT

I hereby consent to and authorize U.S. HealthWorks Medical Group, its affiliates, physicians, employees (USHW) to perform a physical examination and/or medical treatment deemed necessary. Treatment may include, without limitation, any required examination, medical, diagnostic or laboratory tests and medical procedures ordered by the physician(s) to be performed by the designated USHW staff. I understand I may refuse treatment at any time. If I am presenting to USHW for non-regulated substance abuse testing, I voluntarily consent to and authorize USHW to obtain a specimen of my urine, blood, saliva, breath, hair and/or other specimen, to determine the presence of drugs and/or alcohol. I understand that certain special medical exams such as physical exams (e.g. fitness for duty, school or sports) and other services are not intended to diagnose medical conditions, determine treatment needs, or replace the medical care of my personal physician.

CONSENT TO USE AND DISCLOSE INFORMATION / RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that USHW desires that I be fully informed about how my protected health information will be used and disclosed. I acknowledge that I have reviewed or have been given an opportunity to review the USHW Notice of Privacy Practices. I may ask for a copy of the notice or can view it electronically at http://www.ushealthworks.com. I acknowledge that I understand how my information will be used and disclosed, and give my voluntary consent to USHW to use and disclose my protected health information for reasons as allowed or required as explained in the Notice.

ASSIGNMENT OF BENEFITS / FINANCIAL RESPONSIBILITY AGREEMENT

- If applicable, where I have insurance coverage to pay for services rendered, I hereby authorize and assign to USHW any and all payments under the terms of my applicable insurance policies, and hereby obligate each payer to make payment directly to USHW for services rendered. If applicable, where I am treated on a private pay basis I understand I am responsible for payment of services in full. I have a right to ask for the charge amounts before electing treatment.
- If applicable, where I am treated for a workers' compensation injury or illness USHW will seek payment from the responsible payer, which is typically the employer or the employer's workers' compensation insurance carrier, in accordance with State or Federal workers' compensation laws.
- If applicable, for employer directed or required services (e.g. drug testing, physicals, medical surveillance) USHW will seek payment from the employer. Individual patients may be responsible for payment only as allowed by State or Federal law.
- Where applicable, I understand that I am responsible to pay for deductibles, copayments and other charges in accordance with my benefit plan and determinations made by health insurance carriers, or charges determined by State or Federal workers' compensation programs, or your employer as allowed by law. Should my account be referred for collection, I understand that I may have to pay collection expenses incurred by USHW, without limitation, court costs and attorney's fees as allowed by law.

By signing this form I acknowledge that I have read and/or had the notice explained to me and I fully understand its contents. I have been given ample opportunity to ask questions, and any questions have been answered satisfactorily.

SIGNATURE

Patient Signature:_____ Date:_____

Patient Name:_____ Date of Birth:_____

A

2-Hole 1/4 2 3/4 c-to-c

U.S. HealthWorks MEDICAL GROUP

AUE

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

EMPLOYER DIRECTED TESTING AND EVALUATIONS

By signing below, I authorize U.S. HealthWorks Medical Group ("USHW") to disclose my protected health information in accordance with the following terms and conditions:

1. USHW may disclose my protected health information to my employer or prospective employer, and/or to any other entity designated for the purpose of evaluating my suitability for initial and/or continued employment; or other activity required by my employer, or law imposed upon my employer.
2. Name of current or prospective employer / designated entity): _____
3. My protected health information shall include the results of test(s) and/or evaluation(s), including diagnoses and medical history relevant to the test(s) and evaluation(s) performed that my employer or prospective employer has ordered or requires. This includes, but is not limited to drug or alcohol screens, physical examinations, mental or physical fitness-for-duty examinations, or other tests and evaluations required.
4. I understand that my health information may not be protected from further disclosure by any entity receiving my information under this authorization if they are not subject to the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Rule or other State/Federal medical confidentiality laws, and that USHW has no control over subsequent disclosures.

MY RIGHTS IN CONNECTION WITH THIS AUTHORIZATION

- This authorization will expire on/or upon the later of; (a) one (1) year from the date of my signature below (b) the date upon which my medical case has been closed and USHW has received full and final payment for services, or (c) when I am no longer employed by the above named employer.
- I may review or obtain a copy of the health information that will be disclosed pursuant to this authorization. A processing and/or copying charge may apply as permitted by law.
- My treatment may not be conditioned on my signing of this authorization unless the sole purpose of my visit(s) to USHW is for my employer, prospective employer or their designated third-party to obtain health information about me.
- I may revoke this authorization at any time, but I must do so in writing and submit the revocation to the clinic where I receive services. My revocation will take effect upon receipt, but shall not apply to disclosures that have already occurred based upon this authorization. Revocation of this authorization may carry consequences related to your employment or prospective employment. Contact your employer for details.
- I have a right to not sign this authorization and/or to limit the information I authorize to be disclosed. However, refusal to grant this authorization or not permit the release of information that your employer requires may violate a condition of employment or prospective employment. Contact your employer for details.
- I have a right to receive a copy of this authorization.

SIGNATURE

Patient Signature: _____ Date: _____

Patient Name: _____ Date of Birth: _____

E

US HealthWorks MEDICAL GROUP
A Dignity Health Member

ES1

EMPLOYMENT EXAM / EXÁMEN DE EMPLEO
HEALTH HISTORY / HISTORIA MÉDICA

In accordance with current law, limit yourself to answering the questions below. Do not disclose any genetic information about you or your relatives.
De acuerdo con ley vigente, limítese a contestar las preguntas; no ofrezca información genética suya o de sus padres.

			PAST MEDICAL / SOCIAL HISTORY				ANTECEDENTES MÉDICOS PERSONALES Y SOCIALES
1	No	Yes/Si	Have you ever had any medical allergies? *¿Alguna vez ha sufrido de alergias médicas?*	7	No	Yes/Si	Do you have any permanent disabilities? *¿Sufre usted de alguna incapacidad permanente?*
2	No	Yes/Si	Have you ever had recurrent illnesses or major injuries? *¿Ha sufrido de enfermedades o lesiones importantes?*	8	No	Yes/Si	Do you use tobacco in any way? If 'Yes' state type and quantity per day. *¿Usa usted algún tipo de tabaco? ¿Si lo hace, indique tipo y cantidad diaria?*
3	No	Yes/Si	Currently on any medications? If YES, list names and dosage below. *¿Toma alguna medicina? Liste los nombres y las dosis abajo.*	9	No	Yes/Si	Do you consume alcohol? If YES, state type and quantity. *¿Consume bebidas alcohólicas? Si responde SI, indique tipo y cantidad.*
4	No	Yes/Si	Have you ever had hospitalizations or surgeries? *¿Alguna vez ha tenido hospitalizaciones u operaciones?*	10	No	Yes/Si	Do you currently have a chronic illness such as: • High blood pressure, heart disease, stroke • Diabetes, thyroid disease, liver disease, kidney disease • Mental illness, seizures or movement disorders? *¿Sufre usted de alguna enfermedad crónica como:* • *Presión alta, enfermedades del corazón, trombosis,* • *Diabetes, enfermedades de la tiroides, hígado o riñones,* • *Enfermedades mentales, convulsiones o movimientos involuntarios?*
5	No	Yes/Si	Have you worked in hazardous environments? Is so, describe. *¿Ha trabajado en ambientes peligrosos? Por favor, describa.*				
6	No	Yes/Si	Have you suffered any work-related injuries/illnesses? *¿Ha sufrido alguna vez una lesión o enfermedad en el trabajo?*				

REVIEW OF SYSTEMS / *REVISION DE SISTEMAS*

HAVE YOU HAD, OR COMMONLY HAVE ANY OF THE FOLLOWING? ***¿HA PRESENTADO USTED, O COMUNMENTE PRESENTA ALGUNA DE LAS SIGUIENTES CONDICIONES?***

10	No	Yes/Si	**CONSTITUTIONAL** ***CONSTITUCIONAL*** Fever, chills, fatigue, body aches or weight gain or loss? *Fiebre, escalofrios, fatiga dolor en el cuerpo o cambios significativos de peso?*	17	No	Yes/Si	**SKIN** ***PIEL*** Skin diseases or problems like color changes, cancer, tumors, cysts or other? *¿Enfermedades de piel como manchas cáncer, tumores, quistes u otros?*
11	No	Yes/Si	**HEAD** ***CABEZA*** Trauma, injuries, or frequent or severe headaches? *¿Golpes, lesiones o dolores de cabeza severos o seguidos?*	18	No	Yes/Si	**EYES** ***OJOS*** Trauma, injuries, infections, pain, burning, itching or light sensitivity? *¿Trauma, lesiones, infeccion, dolor, picazón, quemazón o sensibilidad a la luz?*
12	No	Yes/Si	**CARDIOVASCULAR** ***CARDIOVASCULAR*** Palpitations, shortness of breath, chest pain/pressure, swelling in legs/feet? *¿Palpitaciones, dificultad para respirar, dolor en el pecho, hinchazón en piernas o pies?*	19	No	Yes/Si	**GENITOURINARY** ***GENITOURINARIO*** Blood in urine, painful/frequent urination, kidney stones, venereal diseases? *¿Orina con sangre o dolor, orina frecuente, cálculos de riñón, enfermedades venéreas?*
13	No	Yes/Si	**EARS,NOSE,THROAT** ***OIDOS,NARIZ,GARGANTA*** Ear, nose or throat problems such as decreased hearing, pain, hoarseness, sinus problems, etc.? *¿Problemas de oido, nariz o garganta como sordera, dolor, ronquera, sinusitis, etc.?*	20	No	Yes/Si	**MUSCULOSKELETAL** ***MUSCULOSQUELÉTICO*** Joint pain, neck or back pain, broken bones? *¿Dolor en las articulaciones, dolor en la espalda o el cuello, fracturas?*
				21	No	Yes/Si	**ENDOCRINE** ***ENDOCRINO*** Increased appetite or thirst, increased urination, hair loss, osteoporosis? *¿Aumento de la sed, apetito u orina, perdida del cabello, osteoporosis?*
14	No	Yes/Si	**RESPIRATORY** ***RESPIRATORIO*** Asthma, frequent coughing, bronchitis, tuberculosis or coughing of blood? *¿Asma, tos frecuente, bronquitis, tuberculosis, tos con sangre?*	22	No	Yes/Si	**NEUROLOGICAL** ***NEUROLÓGICO*** Dizziness, muscle weakness, numbness? *¿Mareos o vértigo, debilidad muscular, falta de sensación?*
15	No	Yes/Si	**GASTROINTESTINAL** ***GASTROINTESTINAL*** Abdominal problems such as pain, reflux, nausea, vomiting, ulcers, black stools, diarrhea, constipation, hemorrhoids, diverticulitis, liver disease? *¿Dolor abdominal, indigestión o reflujo, nausea o vómitos, vómitos o heces con sangre, constipación, diarrea, úlceras digestivas, diverticulitis?*	23	No	Yes/Si	**FOR WOMEN *ONLY*** ***PARA MUJERES SOLAMENTE*** Painful or irregular menstruation, vaginal discharge or pain? Are you pregnant? Last menstrual period? _____ *¿Menstruación o periodos dolorosos o irregulares, secreciones o dolor vaginal? ¿Esta embarazada? Último periodo menstrual:* _____
16	No	Yes/Si	**BLOOD DISORDERS, CANCER** **ENFERMEDADES DE LA SANGRE** Anemia, spontaneous or easy bleeding, bruising, cancer? *¿Anemia, moretones, sangramiento espontáneo, cáncer?*	24	No	Yes/Si	**FOR MEN ONLY** ***PARA HOMBRES SOLAMENTE*** Penile discharge, prostate problems, genital pain or masses? *¿Secresiones en el pene, problemas de próstata, dolor o masas genitales?*

PLEASE WRITE THE NUMBER OF ANY "YES" ANSWERS ABOVE AND EXPLAIN EACH ONE OF THEM HERE.
Por favor, escriba aquí el número de las preguntas en las cuáles haya contestado que SÍ y explíquelas a continuación.

PROVIDER COMMENTS

I certify that the information provided above is correct. *(Certifico que la información suministrada es correcta.)*

Patient Signature *(Firma del Paciente)*:_____ Date *(Fecha)*:_____

☐ Relevant history was discussed with patient.
☐ Advised to follow up with personal physician.

Provider Signature:_____

IF ID LABELS ARE USED, AFFIX HERE AND DO NOT COVER ANY OF THE TEXT ABOVE.

EMPLOYMENT EXAM
HEALTH HISTORY

Name:_____ Incident #:_____ Date:_____

U.S. HealthWorks MEDICAL GROUP

TUBERCULIN (PPD) SCREENING
Questionnaire and Consent Form

Name *(Nombre)*:_____ Employer *(Empleador)*:_____

Date *(Fecha)*:_____ Test (Prueba): ☐ Pre-Placement *(Pre-Empleo)* ☐ Annual *(Anual)* ☐ Two-Step *(Dos Pasos)*

1. Have you had any of the following symptoms during the past year for more than two weeks, NOT associated with a specific illness?
   ¿Ha ud. presentado alguno de estos síntomas en el último a o por mas de dos semanas, NO asociados a una enfermedad especifica?
   a. Unexplained and/or low grade fever. *(Fiebre leve y/o inexplicable)* ☐ Yes / *Si* ☐ No
   b. Night sweats. *(Sudores nocturnos)* ☐ Yes / *Si* ☐ No
   c. Unexplained weight loss of more than 5 lb. *(Pérdida inexplicable de mas de 2 kg de peso)* ☐ Yes / *Si* ☐ No
   d. Persistent cough. *(Tos persistente.)* ☐ Yes / *Si* ☐ No
   e. Coughing up phlegm or blood. *(Tos con flema o sangre.)* ☐ Yes / *Si* ☐ No
   f. Loss of appetite. *(Pérdida del apetito.)* ☐ Yes / *Si* ☐ No
   g. Unusual fatigue. *(Fatiga o cansancio inusual o poco común.)* ☐ Yes / *Si* ☐ No

2. Are you taking any medications? *(¿Esta tomando algún medicamento?)* ☐ Yes / *Si* ☐ No

   Indicate which: *(Indique cuáles)*:_____
   Certain medicines can affect your immune system and change your response to the TB skin test. We may need to test you for this.
   (Algunas medicinas pueden alterar su sistema inmune y alterar su respuesta a la prueba PPD. Quizás tengamos que hacerle exámenes.)

3. Were you ever vaccinated against tuberculosis? *(¿Ha sido vacunado contra la tuberculosis?)* ☐ Yes / *Si* ☐ No

4. Were you vaccinated in the past year? *(¿Ha sido usted vacunado en el último año?)* ☐ Yes / *Si* ☐ No

   Indicate which: *(Indique cuáles)*:_____

5. Have you had an infection in the last month? *(¿Ha tenido alguna infección durante el mes pasado?)* ☐ Yes / *Si* ☐ No

6. Have you ever had a positive TB skin test? *(¿Alguna vez ha tenido una prueba positiva para la tuberculosis?)* ☐ Yes / *Si* ☐ No

7. Have you ever been diagnosed or treated for TB? *(¿Ha sido diagnosticado o tratado antes por tuberculosis?)* ☐ Yes / *Si* ☐ No
   If YES, *(En caso de haber sido tratado,)*
   Which medication did you receive? *(¿Cual medicina recibió?)* _____

8. When was your last chest x-ray? *(¿Cuando le tomaron su última radiografía del pecho?)*_____

PATIENT INSTRUCTIONS / INSTRUCCIONES PARA EL PACIENTE

You have been given a tuberculin skin test that must be read within 48 to 72 hours. If not, it will be considered invalid and will have to be repeated. Please make arrangements with our staff so it can be read properly. Thank you.

(Se le ha administrado la prueba de la tuberculina la cual tiene que leerse en 48 a 72 horas. Si no, la prueba no será válida y deberá repetirse. Por favor, haga arreglos con el personal de la clínica para que la prueba sea leída adecuadamente. Gracias.)

PATIENT STATEMENT / CERTIFICACION DEL PACIENTE

I hereby certify that to the best of my knowledge, I have had neither a severe reaction to tuberculin (PPD) test nor I have had tuberculosis In the past. Therefore, I hereby authorize U.S. HealthWorks to administer to me a tuberculin (PPD) test as required by my prospective/current employer. I understand that if the test reaction is not read in 48 to 72 hours after its administration, it will have to be repeated.

(Yo certifico que hasta donde yo recuerdo, nunca he tenido una reacción severa a la prueba de la tuberculina (PPD) ni he sufrido de tuberculosis en el pasado. Por lo tanto, autorizo a U.S. HealthWorks para que me administre la prueba de la tuberculina (PPD) requerida por mi futuro/presente empleador. Entiendo que si la reacción a la prueba no es leída 48 a 72 horas después de su administración, la prueba tendrá que repetirse.)

Patient Signature *(Firma del Paciente)*:_____ Date *(Fecha)*:_____

TO BE COMPLETED BY THE HEALTHCARE PROFESSIONAL

Single Injection: Manufacturer:_____ Lot #:_____ Expiration:_____
Site: ☐ Right / ☐ Left Forearm Administered by:_____ Date:_____ Time:_____
Induration: ___ millimeters. Read by:_____ Date:_____ Time:_____

Two-Step Injection: Manufacturer:_____ Lot #:_____ Expiration:_____
Site: ☐ Right / ☐ Left Forearm Administered by:_____ Date:_____ Time:_____
Induration: ___ millimeters. Read by:_____ Date:_____ Time:_____
Comments:

According to my findings and the Centers for Disease Control guidelines on Tuberculosis, this employee requires:
☐ No Further Evaluation ☐ Further Evaluation and/or Treatment ☐ A Two-Step PPD

Healthcare Professional: _____ Signature: _____

Clinic:_____ Date:_____