FORM J

STATE OF CALIFORNIA - HEALTH AND HUMAN SERVICES AGENCY

CALIFORNIA DEPARTMENT OF SOCIAL SERVICES
COMMUNITY CARE LICENSING DIVISION

HEALTH SCREENING REPORT - FACILITY PERSONNEL

All personnel, including applicant, licensee or employed staff of Residential Care Facilities for the Elderly, Community Care or Child Care Facilities must demonstrate that their health condition allows them to perform the type of work required. This health appraisal is to be completed by or under the direction of a physician.

A health screening, by or under the direction of a physician must have been performed not more than one year prior to employment or within seven (7) days after employment.

FACILITY NAME: Valley Parent Preschool

FACILITY ADDRESS: 935 Camino Ramon, Danville, CA 94526

PERSON'S NAME | AGE

POSITION TITLE: Parent Teacher Assistant | TYPE OF FACILITY: Preschool | WORK DAYS PER WEEK | WORK HOURS PER DAY

DUTY STATEMENT: Assist teaching staff to supervise and facilitate learning for preschool age children in a cooperative program.

TYPES OF PERSONS SERVED *(Check appropriate items)*

- ☐ Infants
- ☐ Adults
- ☐ Developmentally Disabled
- ☐ Physically Handicapped
- ☑ Children
- ☐ Elderly
- ☐ Mentally Disordered
- ☐ Drug/Alcohol Addiction
- ☐ Other *(specify)* _____

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF MEDICAL INFORMATION CONTAINED IN THIS REPORT.

SIGNATURE OF APPLICANT/LICENSEE OR EMPLOYEE ▶ | ADDRESS | DATE

NOTE TO PHYSICIAN: *Personnel in Residential Care Facilities for the Elderly, Community Care or Child Care Facilities shall be free from communicable disease, and capable of performing assigned tasks. Please complete the following information on the above named person.*

EVALUATION OF GENERAL HEALTH

EVALUATION OF ABILITY TO PERFORM WORK DESCRIBED IN THE ABOVE DUTY STATEMENT

NOTE ANY HEALTH CONDITION THAT WOULD CREATE A HAZARD TO THE PERSON, CLIENTS, CHILDREN OR OTHER PERSONNEL

DATE OF T.B. TEST | ☐ POSITIVE ☐ NEGATIVE | ACTION TAKEN (IF POSITIVE)

DATE OF HEALTH SCREENING | NAME OF PHYSICIAN (PHYSICIAN'S STAMP) | DATE

HEALTH SCREENING BY: (ORIGINAL SIGNATURE) ▶ | **TELEPHONE #** | **DATE**

Valley Parent Preschool Co-Op Volunteer Requirements

Required for each adult who will work in the classroom

Child's name: _____

Class: ☐ MW Preschool ☐ MWF Preschool ☐ TR Preschool ☐ TRF Preschool ☐ AM PK ☐ PM PK

Adult Working in Classroom Information:

First name: _____ Last name: _____

Other names used (e.g. maiden): _____

☐ **Physician Health Exam** (Form 503) signed by a medical provider

☐ **Measles, Mumps, Rubella (MMR)** immunization or blood titer (attach medical documentation):

Immunization Date: _____ **- OR -** Titer dates & results indicating immunity:

Measles: _____ Result: _____

Mumps: _____ Result: _____

Rubella: _____ Result: _____

☐ **Pertussis Vaccination** (attach medical documentation) Date: _____

☐ **TB Screening** (within 60 days of start, good for 4 years) Date: _____
- ☐ TB Screening Form (attach medical documentation) **- OR -**
- ☐ Negative TB Test / Chest X-Ray (attach medical documentation)

☐ **Influenza** (flu shot within the last 12 months or declination statement)
- ☐ Flu shot date: _____ (attach medical documentation) **- OR -**
- ☐ Flu Declination Statement Signed (attach declination form/personal statement)

☐ **COVID-19 Vaccination** (COVID-19 booster shot within the last 12 months or declination statement)
- ☐ COVID-19 vaccine Acceptance/Declination form Signed
- ☐ COVID booster date: _____ (attach medical documentation if applicable)

Note: If your healthcare provider uses the state database CAIR and you have not opted out of this service, your immunization records will be available to the school.

Any medical conditions that staff should be aware of when you work in the classroom? ☐ Yes ☐ No

If yes, please explain: _____

☐ Copy of government issued photo ID (current driver's license, state issued ID, or passport)

A National Sex Offender Public Website Search (NSOPW) will be conducted on all adults who work in the classroom. No action is required on your part.

INFLUENZA VACCINATION WRITTEN DECLINATION FORM

Childcare Worker

Background: In 2015, SB 792 was passed into law requiring influenza (flu) vaccination, or proof of declination, for all individuals working or volunteering in the child care setting.

Annual Requirement: Flu viruses change each year, this is why annual vaccination is required. Under SB 792 employees and volunteers will need to show that they have completed vaccination between August 1 and December 1 of each year.

Opting out: Employees and Volunteers must provide written declination for the influenza vaccine.

Declination of Flu Vaccination: I acknowledge that I am aware of the following facts:

- Influenza is a serious respiratory disease; on average, 36,000 Americans die every year from influenza-related causes.
- Each year an average of 20,000 children under the age of 5 are hospitalized because of influenza complications.
- Severe influenza complications are most common in children younger than 2 years old.
- Children with chronic health problems like asthma, diabetes and disorders of the brain or nervous system are at especially high risk of developing serious flu complications.
- Influenza virus may be shed for up to 24 hours before symptoms begin, increasing the risk of transmission to others.
- Some people with influenza have no symptoms, increasing the risk of transmission to others.
- Influenza virus changes often, making annual vaccination necessary. In California, influenza usually begins circulating in early January and continues through February or March.
- I understand that the influenza vaccine cannot transmit influenza and it does not prevent all disease.

☐ **Knowing these facts, I choose to decline vaccination for this season.**

I acknowledge that influenza vaccination is recommended by the Centers for Disease Control and Prevention for all childcare workers in order to prevent infection from and transmission of influenza and its complications, including death, to young children, my coworkers, my family, and my community.

I may change my mind and accept vaccination later, if a vaccine is available. I have read and fully understand the information on this declination form.

I decline vaccination for the following reason(s). Please check all that apply.

- ☐ I believe I will get influenza if I get the vaccine.
- ☐ I do not like needles.
- ☐ My philosophical or religious beliefs prohibit vaccination.
- ☐ I have an allergy or medical contraindication to receiving the vaccine.
- ☐ I do not wish to say why I decline.
- ☐ Other reason – please tell us.

Signature: _____ Date: _____

Printed Name: _____ Child's Name: _____

California School Employee Tuberculosis (TB) Risk Assessment Questionnaire

(for pre-K, K-12 schools and community college employees, volunteers and contractors)

- Use of this questionnaire is required by California Education Code sections 49406 and 87408.6, and Health and Safety Code sections 1597.055 and 121525-121555.^
- The purpose of this tool is to identify adults with infectious tuberculosis (TB) to prevent them from spreading disease.
- Do not repeat testing unless there are new risk factors since the last negative test.
- Do not treat for latent TB infection (LTBI) until active TB disease has been excluded:
  For individuals with signs or symptoms of TB disease or abnormal chest x-ray consistent with TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing.
  A negative tuberculin skin test (TST) or interferon gamma release assay (IGRA) does not rule out active TB disease.

Name of Person Assessed for TB Risk Factors: _____

Assessment Date: _____ Date of Birth: _____

History of Tuberculosis Disease or Infection (Check appropriate box below)

☐ Yes
- If there is a documented history of positive TB test or TB disease, then a symptom review and chest x-ray (if none performed in the previous 6 months) should be performed at initial hire by a physician, physician assistant, or nurse practitioner. If the x-ray does not have evidence of TB, the person is no longer required to submit to a TB risk assessment or repeat chest x-rays.

☐ No (Assess for Risk Factors for Tuberculosis using box below)

TB testing is recommended if any of the 3 boxes below are checked

☐ One or more sign(s) or symptom(s) of TB disease
- TB symptoms include prolonged cough, coughing up blood, fever, night sweats, weight loss, or excessive fatigue.

☐ Birth, travel, or residence in a country with an elevated TB rate for at least 1 month
- Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries.
- Interferon gamma release assay (IGRA) is preferred over tuberculin skin test (TST) for non-US-born persons.

☐ Close contact to someone with infectious TB disease during lifetime

Treat for LTBI if TB test result is positive and active TB disease is ruled out

^The law requires that a health care provider administer this questionnaire. A health care provider, as defined for this purpose, is any organization, facility, institution or person licensed, certified or otherwise authorized or permitted by state law to deliver or furnish health services. A Certificate of Completion should be completed after screening is completed (page 3).

California School Employee Tuberculosis (TB) Risk Assessment User Guide

(for pre-K, K-12 schools and community college employees, volunteers and contractors)

Background

California law requires that school staff working with children and community college students be free of infectious tuberculosis (TB). These updated laws reflect current federal Centers for Disease Control and Prevention (CDC) recommendations for targeted TB testing. Enacted laws, AB 1667, effective on January 1, 2015, SB 792 on September 1, 2016, and SB 1038 on January 1, 2017, require a TB risk assessment be administered and if risk factors are identified, a TB test and examination be performed by a health care provider to determine that the person is free of infectious tuberculosis. The use of the California School Employee TB Risk Assessment and the Certificate of Completion, developed by the California Department of Public Health (CDPH) and California TB Controllers Association (CTCA) are also required.

AB 1667 impacted the following groups on 1/1/2015:

1. Persons employed by a K-12 school district, or employed under contract, in a certificated or classified position (California Education Code, Section 49406)

2. Persons employed, or employed under contract, by a private or parochial elementary or secondary school, or any nursery school (California Health and Safety Code, Sections 121525 and 121555).

3. Persons providing for the transportation of pupils under authorized contract in public, charter, private or parochial elementary or secondary schools (California Education Code, Section 49406 and California Health and Safety Code, Section 121525).

4. Persons volunteering with frequent or prolonged contact with pupils (California Education Code, Section 49406 and California Health and Safety Code, Section 121545).

SB 792 impacted the following group on 9/1/2016:

Persons employed as a teacher in a child care center (California Health and Safety Code Section 1597.055).

SB 1038 impacted the following group on 1/1/2017:

Persons employed by a community college district in an academic or classified position (California Education Code, Section 87408.6).

Testing for latent TB infection (LTBI)

Because an interferon gamma release assay (IGRA) blood test has increased specificity for TB infection in persons vaccinated with BCG, IGRA is preferred over the tuberculin skin test (TST) in these persons. Most persons born outside the United States have been vaccinated with BCG.

Previous or inactive tuberculosis

Persons with a previous chest radiograph showing findings consistent with previous or inactive TB should be tested for LTBI. In addition to LTBI testing, evaluate for active TB disease.

Negative test for LTBI does not rule out TB disease

It is important to remember that a negative TST or IGRA result does not rule out active TB disease. In fact, a negative TST or IGRA in a person with active TB can be a sign of extensive disease and poor outcome.

Symptoms of TB should trigger evaluation for active TB disease

Persons with any of the following symptoms that are otherwise unexplained should be medically evaluated: cough for more than 2-3 weeks, fevers, night sweats, weight loss, hemoptysis.

Most patients with LTBI should be treated

Because testing of persons at low risk of LTBI should not be done, persons that test positive for LTBI should generally be treated once active TB disease has been ruled out. However, clinicians should not be compelled to treat low risk persons with a positive test for LTBI.

Emphasis on short course for treatment of LTBI

Shorter regimens for treating LTBI have been shown to be more likely to be completed and the 3 month 12-dose regimen has been shown to be as effective as 9 months of isoniazid. Use of these shorter regimens is preferred in most patients. Drug-drug interactions and contact to drug resistant TB are typical reasons these regimens cannot be used.

Repeat risk assessment and testing

If there is a documented history of positive TB test or TB disease, then a symptom review and chest x-ray should be performed at initial hire. Once a person has a documented positive test for TB infection that has been followed by a chest x-ray (CXR) that was determined to be free of infectious TB, the TB risk assessment (and repeat x-rays) is no longer required.

Repeat risk assessments should occur every four years (unless otherwise required) to identify any additional risk factors, and TB testing based on the results of the TB risk assessment. Re-testing should only be done in persons who previously tested negative, and have new risk factors since the last assessment.

Please consult with your local public health department on any other recommendations and mandates that should also be considered.

Certificate of Completion
Tuberculosis Risk Assessment and/or Examination

*To satisfy **job-related requirements** in the California Education Code, Sections 49406 and 87408.6 and the California Health and Safety Code, Sections 1597.055, 121525, 121545 and 121555.*

First and Last Name of the person assessed and/or examined:

_____

Date of assessment and/or examination: _____mo./_____day/_____yr.

Date of Birth: _____mo./_____day/_____yr.

The above named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.

X_____

Signature of Health Care Provider completing the risk assessment and/or examination

Please print, place label or stamp with Health Care Provider Name and Address (include Number, Street, City, State, and Zip Code):

COVID-19 Vaccine Acceptance/Declination Form

2023-2024

VPP strongly recommends that all co-oping adults are up-to-date with their COVID-19 vaccines and booster shots. This helps keep students, staff and other community members safer from the virus. According to the CDC, people who are up to date have lower risk of severe illness, hospitalization and death from COVID-19 than people who are unvaccinated or who have only received the primary series. In addition, the updated COVID-19 boosters can help restore protection that has decreased since previous vaccination. The updated boosters provide added protection against the Omicron subvariants that are more contagious than the previous ones.

Complete the appropriate section below to accept or decline the vaccine: CHOOSE ONE (REQUIRED)

☐ I ACCEPT the COVID-19 vaccination. (Please provide your COVID vaccine record showing a COVID booster in the last 12 months.)

☐ I DECLINE the COVID-19 vaccine at this time. I understand that by declining the vaccine, I continue to be more at risk of acquiring and spreading COVID-19, a serious disease that can result in death. VPP asks that co-oping adults declining the COVID vaccine wear a mask indoors at VPP.

_____

Co-oping Adult Name (Print)

_____ _____

Signature Date