Section 2 must be Completed by Health Professional

Page 1 of 2

	NIAGA	ARA	HE/	\LT	H SYS	STEM
_						

Occupational Health & Safety Department

	Communicable Disease Surveilla			
ool/ Agency:		Program:		
Name:		Classification: STUDE	ENT 🗆 VOLUN	
Hospital Site:		Department:		
D.O.B.		Home Phone:		
Address:				
communicable disease patient care areas of th	isease Protocols require that hospitals must ha for all persons, including employees, physicians, v e Hospital. This requirement must be met prior to N95 respirator mask, you must provide proof of	olunteers, students and con o commencing the first da	ntract workers ay of voluntee	carrying on activitie
	ormation to the Welland Hospital Occupational Hea pational Health & Safety Department and Student or		l authorize the	release of the follow
Signature		Date		
Signature	REQUIRED	Date		
	REQUIRED	Date		
ection 2	REQUIRED	Date		
Ection 2 1. Provide proof			ate	Titre
Ection 2 1. Provide proof	of immunity to Varicella (chickenpox): dence of Varicella immunity OR		ate	Titre
Ection 2 1. Provide proof Laboratory evid	of immunity to Varicella (chickenpox): dence of Varicella immunity OR			Titre #2 Date Vaccinated
1. Provide proof Laboratory evid Proof of 2 Vari	of immunity to Varicella (chickenpox): dence of Varicella immunity OR	Date Vaccin		
2. Provide proof 2. Provide proof 2. Provide proof	of immunity to Varicella (chickenpox): dence of Varicella immunity OR cella vaccines	Da #1 Date Vaccin a:	nated	#2 Date Vaccinated
2. Provide proof 2. Provide proof 2. Provide proof	of immunity to Varicella (chickenpox): dence of Varicella immunity OR cella vaccines f of immunity to Measles, Mumps and Rubel	Da #1 Date Vaccin a:		
Example 2 1. Provide proof Laboratory evid Proof of 2 Vari 2. Provide proo Laboratory evid	of immunity to Varicella (chickenpox): dence of Varicella immunity OR cella vaccines f of immunity to Measles, Mumps and Rubel	Da #1 Date Vaccin a: Da	nated	#2 Date Vaccinated
Example 2 1. Provide proof Laboratory evid Proof of 2 Vari 2. Provide proo Laboratory evid Laboratory evid	of immunity to Varicella (chickenpox): dence of Varicella immunity OR cella vaccines f of immunity to Measles, Mumps and Rubel vidence of Measles immunity	Da #1 Date Vaccin a: Da	ate	#2 Date Vaccinated
Example 2 1. Provide proof Laboratory evid Proof of 2 Vari 2. Provide proo Laboratory evid Laboratory evid	of immunity to Varicella (chickenpox): dence of Varicella immunity OR cella vaccines f of immunity to Measles, Mumps and Rubell	Da #1 Date Vaccin a: Da	ate	#2 Date Vaccinated
 Provide proof Laboratory evid Proof of 2 Vari 2. Provide proo Laboratory evid Laboratory evid 	of immunity to Varicella (chickenpox): dence of Varicella immunity OR cella vaccines f of immunity to Measles, Mumps and Rubell vidence of Measles immunity vidence of Mumps immunity	a:	ate	#2 Date Vaccinated Titre Titre

NIAGARA HEALTH SYSTEM

Occupational Health & Safety Department

3. Documentation of a Two-step (2-Step) tuberculin skin test is also required. An initial tuberculin skin test (Mantou STU PPD) is given. If this test result is 0 - 9 mm of inducation, a second test is also required Tuberculin Skin Testing 1) Date Given: Given By: Date Read: ? Read By: Result: (mm. Inducation) 2) Date Given: Given By: Date Read: Read By: Result: (mm. Inducation) 3) Date Given: Given By: Date Read: Read By: Result: (mm. Inducation) The test results MUST BE recorded in both words and numbers (a.g. Negative 0 mm inducation) Persons who have had previous B.C.G. vaccine should be assessed as above. Persons who are tuberculin positive must have a chest x-ray if they have: • Never been evaluated for a positive TB test or tuberculosis; • Had a previous diagnosis of TB and have never received adequate treatment for TB; or • Pultionany symptions that may be due to TB. The physician must report all positive TB test nearbert received atterwards. Section 2 RECOMMENDED 4. Has the person received the Influenza Vaccine? • Marconneed • Date of last pertussis immunized for tetanus-diphtheria? <th></th> <th>Communicable Disease Surv</th> <th>reillance Program</th>		Communicable Disease Surv	reillance Program
STU PPD) is given. If this test result is 0 - 9 mm of induration, a second test is given in the opposite arm at least on week and no more than four weeks after the first. If it has been over 12 months since the last 2-step test, then a one-step test is also required Tuberculin Skin Testing 1) Date Given: Given By: Date Read: Read By: Result: (mm. Induration) 3) Date Given: Given By: Date Read: Read By: Result: (mm. Induration) Persons who have had previous B.C.G. vaccine should be assessed as above. Persons who are tuberculin positive must have a chest +ray if they have: • Never been evaluated for a positive TB test or tuberculosis; • Had a previous diagnosis of TB and have never received adequate treatment for TB; or • Pulmonary symptoms that may be due to TB. The physician must report all positive TB skin tests to the Public Health Department.	ection 2	REQUIRED	
Tuberculin Skin Testing 1) Date Given: Given By: Date Read. Read By: Result: (mm. Induration) 3) Date Given: Given By: Date Read. Read By: Result: (mm. Induration) 3) Date Given: Given By: Date Read. Read By: Result: (mm. Induration) TB test results <u>MUST BE</u> recorded in both words and numbers (e.g. Negative 0 mm induration) Persons who have had previous B.C.G. vaccine should be assessed as above. Persons who are tuberculin positive must have a chest x-ray if they have: Never been evaluated for a positive TB test or tuberculosis; • • Had a previous diagnosis of TB and have never received adequate treatment for TB; or • • Pulmonary symptoms that may be due to TB. TATCH A COPY OF CHEST X-RAY Chest X-ray: Read Divent TB skin tests to the Public Health Department. Date of Chest X-ray: RecOMMENDED 4. Has the person received the Influenza Vaccine? Date Vaccineed 5. When was the person received the Hepatitits B Vaccine? Date Vaccineed<	5TU PPD) is giv	ven. If this test result is 0 - 9 mm of indu	•
1) Date Given: Given By: Date Read: Read By: Result: (mm. Induration) 2) Date Given: Given By: Date Read: Read By: Result: (mm. Induration) 3) Date Given: Given By: Date Read: Read By: Result: (mm. Induration) 3) Date Given: Given By: Date Read: Read By: Result: (mm. Induration) 3) Date Given: Given By: Date Read: Read By: Result: (mm. Induration) The test results MUST BE recorded in both words and numbers (e.g. Negative 0 mm induration) Presons who have had previous B.C.G. vaccine should be assessed as above. Persons who are tuberculin positive must have a chest x-ray if they have: • Never been evaluated for a positive TB test or tuberculosis; • • Had a previous diagnosis of TB and have never received adequate treatment for TB; or • • Pulmonary symptoms that may be due to TB. The physician must report all positive TB skin tests to the Public Health Department. Date of Chest X-ray:	If it has been o	ver 12 months since the last 2-step test	t, then a one-step test is also required
Read By: Result: (mm: Induration) 2) Date Given: Given By: Date Read: Read By: Result: (mm: Induration) 3) Date Given: Given By: Date Read: Read By: Result: (mm: Induration) 3) Date Given: Given By: Date Read: Read By: Result: (mm: Induration) TB test results <u>MUST BF</u> recorded in both words and numbers (e.g. Negative 0 mm induration) Persons who have had previous B.C.G. vaccine should be assessed as above. Persons who are tuberculin positive must have a chest x-ray if they have: • Never been evaluated for a positive TB test or tuberculosis; • Had a previous diagnosis of TB and have never received adequate treatment for TB; or • Pulmonary symptoms that may be due to TB. The physician must report all positive TB skin tests to the Public Health Department. Date of Chest X-ray:	Tuberculin Skir	n Testing	
Read By: Result: (mm. Induration) 2) Date Given: Given By: Date Read: Read By: Result: (mm. Induration) 3) Date Given: Given By: Date Read: Read By: Result: (mm. Induration) 3) Date Given: Given By: Date Read: Read By: Result: (mm. Induration) TB test results <u>MUST BF</u> recorded in both words and numbers (e.g. Negative 0 mm induration) Persons who are tubercollin positive must have a chest x-ray if they have: • Never been evaluated for a positive TB test or tubercolosis; • Had a previous diagnosis of TB and have never received adequate treatment for TB; or • Pulmonary symptoms that may be due to TB. The physician must report all positive TB skin tests to the Public Health Department. Date of Chest X-ray:	1) Date Given:	Given By:	Date Read:
Read By:	,		
Read By:	2) Date Given:	Given By:	Date Read [.]
3) Date Given: Given By: Date Read: Read By: Result: (mm. Induration) The test results <u>MUST BE</u> recorded in both words and numbers (e.g. Negative 0 mm induration) Persons who have had previous B.C.G. vaccine should be assessed as above. Persons who are tuberculin positive must have a chest x-ray if they have: • Never been evaluated for a positive TB test or tuberculosis; • • Had a previous diagnosis of TB and have never received adequate treatment for TB; or • • Pulmonary symptoms that may be due to TB. • The physician must report all positive TB skin tests to the Public Health Department. Date of Chest X-ray: Date of Chest X-ray:			
Read By:			
TB test results <u>MUST BE</u> recorded in both words and numbers (e.g. Negative 0 mm induration) Persons who have had previous B.C.G. vaccine should be assessed as above. Persons who are tuberculin positive must have a chest x-ray if they have: • Never been evaluated for a positive TB test or tuberculois; • Had a previous diagnosis of TB and have never received adequate treatment for TB; or • Pulmonary symptoms that may be due to TB. • Pulmonary symptoms that may be due to TB. The physician must report all positive TB skin tests to the Public Health Department. • Date of Chest X-ray: Chest X-rays:	,		
Persons who have had previous B.C.G. vaccine should be assessed as above. Persons who are tuberculin positive must have a chest x-ray if they have: Never been evaluated for a positive TB test or tuberculois; Had a previous diagnosis of TB and have never received adequate treatment for TB; or Pulmonary symptoms that may be due to TB. The physician must report all positive TB skin tests to the Public Health Department. Date of Chest X-ray: <u>ATTACH A COPY OF CHEST X-RAY</u> Chest X-rays are to be done initially as a baseline and every 2 years afterwards. Section 2 Has the person received the Influenza Vaccine? No: Date Vaccinated No: Date of last pertussis immunization (i.e. Adacel or Tdap)? Date Vaccinated No: Date of 1st Dose: Date of 1st Dose: Date of 1st Dose: Date of Health Care Professional: Name of Health Care Professional: Comparison of the store of the st	-		、、
 Never been evaluated for a positive TB test or tuberculosis; Had a previous diagnosis of TB and have never received adequate treatment for TB; or Pulmonary symptoms that may be due to TB. The physician must report all positive TB skin tests to the Public Health Department. Date of Chest X-ray:	Persons who ha	ve had previous B.C.G. vaccine should be	
 Had a previous diagnosis of TB and have never received adequate treatment for TB; or Pulmonary symptoms that may be due to TB. The physician must report all positive TB skin tests to the Public Health Department. Date of Chest X-ray: Result:			sis;
The physician must report all positive TB skin tests to the Public Health Department. Date of Chest X-ray:			
Date of Chest X-ray: Result: ATTACH A COPY OF CHEST X-RAY Chest X-rays are to be done initially as a baseline and every 2 years afterwards. Section 2 RECOMMENDED 4. Has the person received the Influenza Vaccine? Date Vaccinated 5. When was the person last immunized for tetanus-diphtheria? Date Vaccinated 6. Date of last pertussis immunization (i.e. Adacel or Tdap)? Date Vaccinated 7. Has this person received the Hepatitis B Vaccine? Yes: No: Date of 1st Dose: Date of 2nd Dose: Date of 3rd Dose: Date of 3rd Dose: Date of 3rd Dose: Health Professional's Signature: Name of Health Care Professional: Please Print Telephone:	 Pulmonary sym 	ptoms that may be due to TB.	
ATTACH A COPY OF CHEST X-RAY Chest X-rays are to be done initally as a baseline and every 2 years afterwards. Section 2 RECOMMENDED 4. Has the person received the Influenza Vaccine? 5. When was the person last immunized for tetanus-diphtheria? 6. Date of last pertussis immunization (i.e. Adacel or Tdap)? 7. Has this person received the Hepatitis B Vaccine? Date of 1st Dose: Date of 1st Dose: Date of 3rd Dose: Date of 3rd Dose: Date of 3rd Dose: Please Print Address: Please Print	The physician m	oust report all positive TB skin tests to the	Public Health Department.
ATTACH A COPY OF CHEST X-RAY Chest X-rays are to be done initally as a baseline and every 2 years afterwards. Section 2 RECOMMENDED 4. Has the person received the Influenza Vaccine? 5. When was the person last immunized for tetanus-diphtheria? 6. Date of last pertussis immunization (i.e. Adacel or Tdap)? 7. Has this person received the Hepatitis B Vaccine? Date Vaccinated 7. Has this person received the Hepatitis B Vaccine? Date of 1st Dose: Date of 3rd Dose: Health Professional's Signature: Name of Health Care Professional: Please Print Address: Please Print			
Chest X-rays are to be done initially as a baseline and every 2 years afterwards. Section 2 RECOMMENDED 4. Has the person received the Influenza Vaccine? Date Vaccinated 5. When was the person last immunized for tetanus-diphtheria? Date Vaccinated 6. Date of last pertussis immunization (i.e. Adacel or Tdap)? Date Vaccinated 7. Has this person received the Hepatitis B Vaccine? Yes: No: Date of 1st Dose: Date of 2nd Dose: Date of 3rd Dose: Date of 3rd Dose: Date of 3rd Dose: Please Print Address:	Date of Chest X		
Section 2 RECOMMENDED 4. Has the person received the Influenza Vaccine?			
4. Has the person received the Influenza Vaccine? Date Vaccinated 5. When was the person last immunized for tetanus-diphtheria? Date Vaccinated 6. Date of last pertussis immunization (i.e. Adacel or Tdap)? Date Vaccinated 7. Has this person received the Hepatitis B Vaccine? Date of 1st Dose: Date of 2nd Dose: Date of 3rd Dose: Health Professional's Signature: Name of Health Care Professional: Address: Please Print	-	•	y 2 years afterwards.
S. When was the person last immunized for tetanus-diphtheria? Date Vaccinated Date Vaccinate Date Vaccina	Section 2	RECOMMENDED	
S. When was the person last immunized for tetanus-diphtheria? Date Vaccinated Date Vaccinate Date Vaccina			
5. When was the person last immunized for tetanus-diphtheria? 6. Date of last pertussis immunization (i.e. Adacel or Tdap)? 7. Has this person received the Hepatitis B Vaccine? Date of 1st Dose: Date of 2nd Dose: Date of 3rd Dose: Health Professional's Signature: Name of Health Care Professional: Address: Please Print Telephone:	4. Has the person	received the Influenza Vaccine?	Date Vaccinated
6. Date of last pertussis immunization (i.e. Adacel or Tdap)? 7. Has this person received the Hepatitis B Vaccine? Date of 1st Dose: Date of 2nd Dose: Date of 3rd Dose: Health Professional's Signature: Name of Health Care Professional: Address:	5. When was the p	erson last immunized for tetanus-diphthei	
7. Has this person received the Hepatitis B Vaccine? Date of 1st Dose: Date of 2nd Dose: Date of 3rd Dose: Health Professional's Signature: Name of Health Care Professional: Address:	C Data of loot part	······································	
Date of 1st Dose:	6. Date of last pert	ussis immunization (i.e. Adacei or Tdap)?	
Date of 2nd Dose:	7. Has this person	received the Hepatitis B Vaccine?	Yes: No:
Date of 3rd Dose: Health Professional's Signature: Name of Health Care Professional: Please Print Address: Telephone:			
Health Professional's Signature: Name of Health Care Professional: Please Print Address: Telephone:			
Name of Health Care Professional:		Date of 3rd Do	ose:
Address: Telephone:	Health Professional's S	Signature:	
Address: Telephone:	Name of Health Care P	Professional:	
	A -1-1-1-0-0-0.		— · · ·
Date:	Address:		