NIAGARA HEALTH SYSTEM

Occupational Health & Safety Department
Communicable Disease Surveillance Program

School/ Agency:			**Program:**

Section 1 to be Completed by Applicant

Name: _____ Classification: STUDENT □ VOLUNTEER □ CONTRACT □

Hospital Site: _____ Department: _____

D.O.B. _____ Home Phone: _____

Address: _____

E-mail address: _____

The Communicable Disease Protocols require that hospitals must have document proof of immunization and/or history of specific communicable disease for all persons, including employees, physicians, volunteers, students and contract workers carrying on activities in patient care areas of the Hospital. **This requirement must be met prior to commencing the first day of volunteering/placement. If you have been fitted for an N95 respirator mask, you must provide proof of the date tested and type of mask you were passed on.**

Please provide this information to the Welland Hospital Occupational Health & Safety Department . I authorize the release of the following information to the Occupational Health & Safety Department and Student or Volunteer resources.

Signature _____ Date _____

Section 2 REQUIRED

Section 2 must be Completed by Health Professional

1. Provide proof of immunity to Varicella (chickenpox):

Laboratory evidence of Varicella immunity	_____ Date	_____ Titre
OR		
Proof of 2 Varicella vaccines	_____ #1 Date Vaccinated	_____ #2 Date Vaccinated

2. Provide proof of immunity to Measles, Mumps and Rubella:

Laboratory evidence of Measles immunity	_____ Date	_____ Titre
Laboratory evidence of Mumps immunity	_____ Date	_____ Titre
Laboratory evidence of Rubella immunity	_____ Date	_____ Titre
OR		
Proof of 2 MMR (Measles, Mumps, Rubella) vaccines	_____ #1 Date Vaccinated	_____ #2 Date Vaccinated

ATTACH A COPY OF LABORATORY IMMUNITY BLOOD WORK RESULTS TO THIS FORM

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Section 2 REQUIRED

3. Documentation of a Two-step (2-Step) tuberculin skin test is also required. An initial tuberculin skin test (Mantoux, 5TU PPD) is given. If this test result is 0 - 9 mm of induration, **a second test is given in the opposite arm at least one 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)

2) 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 MUST BE 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: _____ Result: _____

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? _____ 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: _____

Health Professional's Signature: _____

Name of Health Care Professional: _____ Please Print

Address: _____ Telephone: _____

_____ Date: _____

Section 2 must be Completed by Health Professional