North Wellington Health Care & Groves Memorial Community Hospital
Staff/Volunteer/Student/Physician/Contract Worker Immunization Record

Mandatory Immunizations and Tuberculosis Screening:

Tuberculosis:
Staff/physicians/students/midwives/nurse practitioners/volunteers/contract workers whose tuberculin status is unknown and those previously indentified as tuberculin negative, require a baseline two-step Mantoux skin test unless they have: documented results of a prior two-step test OR documentation of a negative TB skin test within the last 12 months OR 2 or more documented negative TB skin tests at any time but the most recent was > 12 months ago**.** In this case a single step test may be given. This testing must be done prior to placement or within 14 days of that time. It is essential to have accurate baseline information at the beginning of your placement, as this is the comparison that is used in the event of an exposure. Tuberculin skin testing results must be recorded in millimeters of induration.

A chest x ray must be done on individuals who have never been evaluated for a positive TB skin test or who have had a previous diagnosis of tuberculosis but have never received adequate treatment. Further assessment may be required under the direction of a physician.

It is also necessary to provide documentation of immunity/immune status to the communicable diseases of rubella (German measles), measles (red), mumps and varicella (chicken pox). There is more than one way to do this:

- **Rubella** **One of the following is acceptable**
  - Physician or nurse documentation of immunization on or after the first birthday
  - Laboratory evidence of immunity (have blood drawn and tested)

  A history of having had rubella is not acceptable as this disease can be confused with other viruses.

- **Mumps** **One of the following is acceptable**
  - Laboratory evidence of immunity (have blood drawn and tested)
  - Documentation of two doses of mumps vaccine on or after the first birthday
  - Documentation of laboratory confirmed mumps

- **Measles** **One of the following is acceptable**
  - Documentation of 2 doses of measles vaccine on or after the 1st birthday
  - Laboratory evidence of immunity (have blood drawn and tested)

- **Varicella** **One of the following is acceptable**
  - Laboratory confirmation of disease
  - Laboratory evidence of immunity (blood drawn and tested)
  - Documentation of two doses of varicella vaccine
  - Diagnosis or verification of a history of typical varicella (chicken pox) or herpes zoster (shingles) by a health care provider (self provided history is not acceptable)

Hepatitis B Vaccine is not mandatory but all staff must disclose their status, i.e. for those persons who have been immunized a Hepatitis B Antibody titer (positive or negative result) must be provided. Hepatitis B immunity is highly recommended for all persons that may have any contact with human blood and body fluids.

Tetanus/Diphtheria/Pertussis vaccine is not mandatory but desirable. Tetanus booster doses are given every 10 years but may be given if 5 years has elapsed since the last dose. A single dose of dTap (Tetanus, diphtheria, acellular pertussis) should be offered to all health care workers who have not previously received an adolescent or adult dose of dTap.

Influenza Vaccine is not mandatory but desirable. It is expected that all staff will have an annual influenza vaccine in accordance with Wellington Health Care Alliance's influenza policy. Persons not immunized will be excluded from patient care areas in the event of an influenza outbreak unless they take appropriate anti-viral medication for the duration of the outbreak.

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Name: _____ **Phone:** _____ **DOB:** _____

I, _____ agree to release the information provided below to Occupational Health Services of North Wellington Health Care/ Groves Memorial Community Hospital. I understand that Human Resources will be allowed to know the status of my compliance (no actual result will be provided-only compliance or non compliance). Date: _____

Tuberculin Testing (see information above):
Previous documented two step:
Date of test #1_____Result: Pos ( ) Neg ( ) Induration in mm_____
Date of test #2_____Result: Pos ( ) Neg ( ) Induration in mm _____
Recent tests:
Date of test _____Result: Pos ( ) Neg ( ) Induration in mm_____
Date of test _____Result: Pos ( ) Neg ( ) Induration in mm _____

Rubella: Documented immunization on or after 1st birthday OR laboratory evidence. Evidence of immunity to rubella is mandatory.

Evidence of Immunity ( ) Yes ( ) No
Lab evidence ( ) Date: _____
OR Vaccine (on or after first birthday) ( ) Yes ( ) No
Date of vaccine: _____

Red Measles: Documentation of two doses of measles vaccine (on or after the first birthday) OR laboratory evidence. Evidence of immunity to measles is mandatory.

Evidence of Immunity ( ) Yes ( ) No
Lab evidence ( ) Date: _____
OR Two documented doses of vaccine (on or after first birthday) ( ) Yes ( ) No
Date of first dose: _____ Date of second dose: _____

Mumps: Documentation of two doses of mumps vaccine (or MMR) on or after the first birthday OR laboratory evidence. Evidence of immunity to mumps is mandatory.

Evidence of Immunity ( ) Yes ( ) No
Lab evidence ( ) Date: _____
OR Documentation of laboratory confirmed mumps ( ) Date: _____
OR Two documented doses of vaccine (on or after first birthday) ( ) Yes ( ) No
Date of first dose: _____ Date of second dose: _____

Varicella (Chicken Pox/Shingles): Evidence of one of the following is mandatory.

Evidence of Immunity ( ) Yes ( ) No
Lab evidence ( ) Date: _____
OR Documentation of laboratory confirmed varicella ( ) Date: _____
OR Two documented doses of vaccine ( ) Yes ( ) No
Date of first dose: _____ Date of second dose: _____
OR Diagnosis or verification of a history of typical varicella (chicken pox) or herpes zoster (shingles) by a health care provider ( ) Yes ( ) No Date of illness _____

Tetanus/Diphtheria: (not mandatory but desirable) Date: _____
Was acellular pertussis given? Yes ___ No ___

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Hepatitis B: Is not mandatory but highly recommended for persons who may have exposure to blood and bodily fluids

Date of vaccine: #1_____
#2_____
#3_____
Booster(s) if given: Date: _____
Titer: Date_____ Result: _____

Influenza Vaccination: Date: _____ Type: _____

Respirator Fit Testing: Date: _____ Make: _____
Model: _____

Other: _____

Health Care Provider Signature: _____

Title: _____ Date: _____