HEALTH REVIEW FORM

☐ Paid Staff ☐ Volunteer* ☐ Co-op Student* ☐ Student ☐ Sponsored Student
(*refer to Volunteer *Welcome* document)
☐St. Joseph's ☐Mt. Hope ☐Parkwood Institute Main Building ☐Parkwood Institute Mental Health Care ☐Southwest Centre

Information obtained is strictly confidential, and shall not be released to any source internally or externally without written consent of the employee named herein.

First Name:	Middle Name:	Last Name:
Address:		
Telephone Number:	Date of Birth (dd/mm/yyyy):	Country of Birth (only Volunteers/Students to complete):
Department/Unit:	Position:	
Family Physician:	Start Date (dd/mm/yyyy):	
Emergency Contact person:	Emergency Contact Home #	Emergency Contact Business/Cell#

Do you have any food/drug allergies or any emergent medical conditions (eg, asthma, epilepsy, diabetes, heart condition) that you feel Occupational Health should be aware of?
☐ Yes ☐ No _____
Do you have a disability that requires an accommodation? ☐ Yes ☐ No
(if yes, provide details) _____

TUBERCULOSIS (TB) SCREENING

If 1st step is negative, 2nd step must be given 1 to 3 weeks after the 1st step.				
1st step	Date given:	Date read:	Result(+ or -)	Induration(mm)
2nd step	Date given:	Date read:	Result(+ or -)	Induration(mm)
If the above negative 2 step TB test was not completed within the last 12 months, a 1 step TB test must be completed				
1st step	Date given:	Date read:	Result(+ or -)	Induration(mm)
If 1st or 2nd step test is POSITIVE(greater than 10mm induration), chest x-ray is required. (Chest X-ray must be taken after the positive TB skin test)				
X-ray	Date	Result :Provide copy of results		
	Endemic Travel History Yes No	Treatment for TB infection Yes No	Date of Treatment	

PROOF OF IMMUNITY

MEASLES	Laboratory evidence of immunity	Date of test	Result: Immune ☐ Non Immune ☐
	1 MMR after1st birthday plus an additional measles booster or 2nd MMR	Date of 1st MMR	Please check one ☐ Measles Booster Date: ☐ 2nd MMR Date:
MUMPS	Laboratory evidence of immunity	Date of test	Result: Immune ☐ Non Immune ☐
	1 MMR after1st birthday plus an additional measles booster or 2nd MMR	Date of 1st MMR	Please check one ☐ Measles Booster Date: ☐ 2nd MMR Date:
RUBELLA	Laboratory evidence of immunity	Date of test	Result: Immune ☐ Non Immune ☐
	1 MMR after1st birthday	Date of 1st MMR	
VARICELLA	Varicella Vaccine (2 doses required) OR	Date of 1dst dose	Date of 2nd dose
	Laboratory evidence of immunity OR	Date of test	Result: Immune ☐ Non Immune ☐
	Laboratory evidence of chicken pox or shingles	Date of test	Result: Varicella zoster detected ☐

IMMUNIZATION STATUS

Hepatitis B	Laboratory evidence of immunity OR	Date of test	Result: Immune ☐ Non Immune ☐
	Vaccination	Received vaccine Yes ☐ No ☐	If yes, year series was completed: Laboratory evidence of immunity post series Yes ☐ No ☐ Not tested ☐
Tetanus/ Diphtheria/Pertussis (Tdap)	Tdap is recommended for all adults	☐ Tdap Date: _____ ☐ Td (Tetanus/Diphtheria) Year of most recent booster :_____	
Influenza	Highly recommended every year	Date of most recent vaccine:	

Have you been fit tested within the last 2 years to wear an N95 respirator Yes No If yes please attached proof.

Completed by: Physician Name: _____ Signature: _____ Date: _____

Contact information of physician completing the form: Address and Phone #_____

I, _____, agree to release the above information to Occupational Health and Safety at St Joseph's Health Care. I understand that my leader will be informed of my compliance status in relation to the mandatory immunization requirements as outlined in the Communicable Disease Surveillance Protocols for Ontario Hospitals.