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				
1 step test	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 *OR*	Date of test	Result: Immune ☐ Non Immune ☐
	1 MMR after1st birthday plus an additional measles booster *OR* a 2nd MMR	Date of 1st MMR	Please check one ☐ Measles booster Date: ☐ 2nd MMR Date:
Mumps	Laboratory evidence of immunity *OR*	Date of test	Result: Immune ☐ Non Immune ☐
	1 MMR after1st birthday plus an additional measles booster OR a 2nd MMR	Date of 1st MMR	Please check one ☐ Measles booster Date: ☐ 2nd MMR Date:
Rubella	Laboratory evidence of immunity *OR*	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: _____ If never received Tdap ☐ 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 immunization requirements as outlined in the Communicable Disease Surveillance Protocols for Ontario Hospitals.