ST JOSEPH's HEALTH CARE LONDON

HEALTH REVIEW FORM

☐VOLUNTEER ☐CO-OP STUDENT ☐POST SECONDARY STUDENT ☐SPONSORED STUDENT

Proof of immunization is required and includes any of the following: Vaccination records from yellow immunization cards, Immigration records, notes from a physician's office, copies of laboratory reports (titre levels), health unit records and/or other hospital electronic immunization records.

LAST NAME	**FIRST NAME**	**MIDDLE INITIAL**
ADDRESS		
PRIMARY PHONE #: (May be home or cell #)	**EMAIL (OPTIONAL)**	
COUNTRY OF BIRTH	**DATE OF BIRTH (mm/dd/yyyy)**	
FAMILY PHYSICIAN	**EMERGENCY CONTACT PERSON**	**EMERGENCY CONTACT #**
FACILITY WHERE YOU WILL BE VOLUNTEERING(Please check all that apply) ☐ St. Joseph's Hospital ☐ Mt. Hope ☐ Parkwood Institute Main Building ☐ Parkwood Institute Mental Health Care ☐ Southwest Centre		

All St. Joseph's Staff and affiliates require a 2 step TB Skin test (TST). The 2 step TB skin test is given 1- 52 weeks apart from the first single TST. *A TB skin test may be given on the same day as a live vaccine, but otherwise may not be administered until at least 4 weeks have elapsed.*

1st step:	Date Administered:	Date read:	Result (+ or -)	Induration (mm)
2nd step:	Date Administered:	Date read:	Result (+ or -)	Induration (mm)
If 2-Step TB test was completed more than 12 months ago, a 1-Step TB test must be completed.				
1st step:	Date Administered:	Date read:	Result (+ or -)	Induration (mm)
If 1st or 2nd test is POSITIVE (i.e. greater than 10mm induration): Chest x-ray is required to be completed, post-positive test.				
X-ray:	Date:	Result**:**		
Did you receive treatment for TB ☐ Yes ☐ No		Date of Treatment:		
Endemic Travel History		☐ Yes ☐ No Please explain:		

Immunizations (MMR/VZV):

Measles Mumps and Rubella Vaccination (MMR) – Proof of 2 doses on or after your first birthday at least 4 weeks apart , or Laboratory evidence (blood work) of immunity	Date of blood test:	Result: ☐ Immune ☐ Not Immune
	Date 1st MMR:	Date 2nd MMR:
Varicella/Chickenpox (VZV) – Proof of 2 doses at least 4 weeks apart, or Laboratory evidence (blood work)	Date of blood test:	Result: ☐ Immune ☐ Not Immune
	Date 1st VZV:	Date 2nd VZV:
Hepatitis B: *Not Mandatory for Volunteers* Confirmatory titre test result if available	Received vaccine? ☐ Yes ☐ No	Date of titre test: ☐ Immune ☐ Not Immune ☐ Not tested
Influenza (Highly recommended each year)	Date of most recent vaccine:	

Do you have any food/drug allergies or any emergent medical conditions (e.g., asthma, epilepsy, diabetes, heart condition) that you feel Occupational Health should be aware of? ☐ Yes ☐ No (If yes, provide details)

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Do you have a disability that requires an accommodation? ☐ Yes ☐ No
(If yes, provide details)

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PLEASE NOTE:

It is not permitted to have relatives complete and sign this record.

If form is being completed by the Physician, Physician contact information and signature required.

Physician: ______________________________ Signature: ______________________________
PRINT NAME

Date:______________________________

Address:____

Phone#:______________________________

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

For Volunteer

I,______________________________, agree to release the above information to Occupational Health and Safety at St Joseph's Health Care London

Name:______________________________

Signature:______________________________

Date:______________________________

Volunteers/Co-op Students/Sponsored Students:
Completed, signed forms to be sent to: OHSS@sjhc.london.on.ca or fax to 519-646-6235.

Post-Secondary Students:
Completed, signed forms to be sent to your educational institution

INCOMPLETE FORMS WILL BE SENT BACK TO YOU AND WILL DELAY YOUR START DATE.