CONFIDENTIAL EMPLOYEE IMMUNIZATION FORM

SECTION A:

Name: (PLEASE PRINT)_____Date of Birth:_____

PHIN:_____MHSC:_____Phone #: (H)_____(C)_____

Facility and Department of Hire:_____Occupation/Position_____Employee ID:_____

Please read and sign: I have read, agree, and provide consent to the terms on both sides of this form:

Signature (REQUIRED):_____Date:_____

Compliance with the SH-SS Immunization Policy CLI.8011.PL.008 is a condition of employment.

SECTION B: REQUIRED IMMUNIZATIONS/TESTING – READ INFORMATION ON REVERSE

1. MEASLES (Red Measles/Rubeola) Required: 2 doses or positive titre	Measles Titre Result:_____ Date: _____	OR Measles Vaccine Date #1: _____ Date #2: _____	MMR VACCINE: Dose #1 Date: _____ Dose #2 Date: _____
2. MUMPS Required: 2 doses or positive titre	Mumps Titre Result:_____ Date: _____	OR Mumps Vaccine Date #1: _____ Date #2: _____	Documentation of 2 doses of MMR (preferred) OR documentation of measles, mumps, and rubella specific antibodies
3. RUBELLA (German Measles) Required: 1 dose or positive titre	Rubella Titre Result:_____ Date: _____	OR Rubella Vaccine Date #1: _____ Date #2: _____	If susceptible to rubella, 1 documented dose of MMR is required
4. CHICKENPOX (Evidence of immunity required: if not immune, requires 2 doses)	Chickenpox Titre Result:_____Date of Titre: _____ Vaccine Date: Dose #1_____Vaccine Date: Dose #2_____		
5. HEPATITIS B (Required: recognized immunization schedule and a positive anti-HBs titre; If negative anti-HBs titre, give booster and check titres. Still negative, complete second 3 dose series.	Dose 1_____Dose 2_____Dose 3_____ HB Titre Result (anti-HBs):_____Date of Titre: _____ Dose 4_____Dose 5_____Dose 6_____ HB Titre Result (anti-HBs):_____Date of Titre: _____		
6. Tdap (see reverse)	Date of Tdap: _____		
7. TUBERCULOSIS Measure induration, not redness at test site. Ideally tests for 2 step are 7-28 days apart.	BCG Vaccine: Date of vaccine (if applicable): _____ Scar present: circle YES or NO circle LEFT or RIGHT Site:_____ 2 STEP Tuberculin Skin Test (TST) #1 Date read:_____Result in mm: _____ #2 Date read:_____Result in mm: _____		Most Recent TST: (A TST is required within the last year) Date read:_____ Result in mm:_____
Chest x ray required if TST is positive, greater than 10 mm	Chest X-ray Done? Circle YES or NO Date of X-ray:_____Result:_____ Referred for Follow-up? YES or NO To Whom: _____ *Include copy of chest x-ray report and documentation of referral follow-up (if applicable).*		

NOTES: _____

_____

_____

NAME OF PHYSICIAN/NURSE:_____Signature:_____Date:_____

NAME OF PHYSICIAN/NURSE:_____Signature:_____Date: _____

Requirements for Completion

For all Vaccines- Documented proof of immunization or confirmed immunity is required.

1-3. MMR- Lab confirmed immunity (titre) of measles, mumps or rubella OR documentation of immunization in accordance with NACI guidelines. Please attach lab report.

4. Chicken Pox (varicella) - Lab confirmed immunity (titre) OR 2 doses of varicella vaccine. Please attach lab report.

5. Hepatitis B- Required for all staff who may be exposed to blood and body fluids or who may be at increased risk of a needlestick/sharps injury, bites or spills/splashes. Best practice is documentation of a complete series of HB containing vaccine, with lab confirmed immunity (titre). Titre should be done approximately one month after the last dose of vaccine. If no antibodies, give dose of Hepatitis B booster, check titres, if positive – no further doses. If negative, then complete a second 3 dose series, check titres one month after completing the series. A verbal history of vaccination from a knowledgeable healthcare worker, who was vaccinated as an adult with a three dose series, is acceptable evidence of documentation if paper documentation not available. Will require lab confirmed immunity (titre).

6. Tetanus Diphtheria Pertussis - Adequate Tetanus and Diphtheria immunization must include Pertussis is once as an adult (>18yrs) regardless of adolescent dose year for health care providers. Td recommended every 10 years after adult dose of Tdap.

7. Tuberculosis Skin Test - History and date of BCG vaccine and/or evidence of a BCG scar should be documented.TST should not be given to those:

1) Who have received measles or other live virus immunization within the past 4 weeks, as this has been shown to increase the likelihood of false-negative TST results. However, if the opportunity to perform the TST might be missed, the TST should not be delayed for live virus vaccines. (NOTE that a TST may be administered before or even on the same day as the other immunizations but at a different site.);

2) With positive, severe blistering TST reactions in the past or with extensive burns or eczema present over TST testing sites;

3) With documented active TB or a well-documented history of adequate treatment for TB infection or disease in the past;

4) With current major viral infections. A two-step tuberculin skin test (TST) is required once in a life-time, with results recorded. Results are to be recorded in millimeters of induration. A TST update is required if no TST has been done in the last 12 months. Induration is measured **NOT** erythema or redness. A PA chest x-ray is required if TST is 10 mm or greater, as well as an assessment re latent TB. Avoid testing an individual who is taking corticosteroids (≥ 15 mg of prednisone/day for 2 weeks) or immunosuppressive drugs.

Read the information below and sign the front (top) of the form where indicated:

(1) I understand that should I be involved in an exposure incident of blood or body fluid, for the health and safety of myself and any patients or contacts, I am expected to comply with post exposure protocols including submission to tests and/or disclosure to appropriate health persons any applicable condition that could adversely impact a patient/client for purposes of assessment and/or treatment.

(2) I understand that immunizations and health screening tests are a condition of employment within Southern Health-Santé Sud.

(3) I understand that recommendations or requirements may change based on new information and evidence, outbreaks of communicable diseases. I accept that it is my responsibility to follow through on immune status recommendations or requirements of the employer.

(4) I understand that my personal health information is confidential, and will only be used by those directly involved and only for the stated purposes of my employer. This may include Occupational Safety and Health, and/or designated individuals. I understand that only the minimal amount of information required will be used.

(5) I agree that if required, Occupational Safety and Health may obtain and use from an external source, records of immunizations, testing, or treatment of infectious diseases that fall within the scope of this document. An external source includes but is not limited to my family physician, public health, specialty care, healthcare institutions, laboratories, and immunization registries.

(6) If additional testing for or treatment of a communicable disease within the scope of this document is conducted by occupational health or infection control of a healthcare institution, or by public health or another institution in the community, I agree that this information may be received/shared, within the parameters of confidentiality as required by applicable Acts/Legislation and only with minimum information necessary to address the issue

(7) I understand that my immune status record will be kept on a secure database system.

(8) I have read the Policy Occupational Health: Immunizations for Health Care Workers (CLI.8011.PL.008).

(9) I authorize the Occupational Health Nurse to access my immunization records through Public Health Information Management System (PHIMS) and/or my electronic patient record; and to communicate with healthcare providers such as public health nurses or family physicians providing care to me regarding vaccinations or the results of tests done for the purposes of this employee immunization record.

Immunization and testing requirements along with schedules may change from time to time. Occupational Health and Safety references: PHAC, NACI, CIG, TB guide and may consult with Health Authorities, Medical Officers of Health, and Ministry of Health on relevant issues and best practice. Information is logged into an electronic database.

EMPLOYEES TO BRING THIS FORM AND ANY IMMUNIZATION DOCUMENTATION TO APPOINTMENT FOR THE OCCUPATIONAL HEALTH NURSE TO REVIEW. FOR ANY QUESTIONS, CONTACT THE OCCUPATIONAL HEALTH NURSE AT (204) 428-2722.