Hamilton Health Sciences

Name of Learner/applicant: _____

PRE-PLACEMENT IMMUNIZATION FORM

REQUIRED FOR LEARNER: ☐ **OTHER:** ☐ (specify) _____

SPECIFY SITE: HGH ☐ SPH ☐ WLMH ☐ FHT (Family Health Team) ☐ MUMC ☐
RJCHC (Ron Joyce Children's Health Centre) ☐ JH&CC ☐ RRC (Regional Rehabilitation Centre) ☐

***Note to Applicant: If you are applying for a new learning opportunity and have had a recent health clearance by Employee Health Service (EHS) within the last year, please indicate ☐ and provide us with your email address and phone number.**

_____

EHS will review any records they have on file, and advise us of any required updates.

Clearance email to be sent to the HHS staff member indicated here:

For individuals requiring health clearance for an upcoming experience, have your Health Care Provider complete this form.

_____

Dear Health Care Provider;

(Name of Learner/Applicant)_____ is seeking a position at Hamilton Health Sciences. The Ontario Hospital Association and Ontario Medical Association (OHA/OMA) requires that everyone working in hospitals fulfills the following requirements.

Please complete this immunization form for this individual. Thank you.

Has your patient received these *Mandatory* requirements?:

Step 1) Two doses of MMR (Measles, Mumps, Rubella) vaccine given at least 4 weeks apart on, or after, their first birthday?	**Yes** ☐ **No** ☐	**If yes**, document the relevant dates and then proceed to step 5. Date of Vaccine #1: _____ Date of Vaccine #2: _____ ***If no,** complete steps 2 to 4.
***Step 2)* Evidence of Rubella immunity is required.**		Document receipt of one dose of live Rubella vaccine (MMR or equivalent Rubella vaccine): Date of Vaccine:_____ **OR** Indicate you are providing laboratory evidence of Rubella immunity ☐ (Attach paperwork that shows positive titre).
***Step 3)* Evidence of Measles immunity is required.**		Document receipt of two doses of live Measles vaccine (MMR or equivalent vaccine) given on, or after their first birthday: Date of Vaccine #1: _____ Date of Vaccine # 2: _____ **OR** Indicate you are providing laboratory evidence of Measles immunity ☐ (Attach paperwork that shows positive titre).

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Step 4) **Evidence of Mumps immunity is required.**		Document date of receipt of <u>two doses</u> of Mumps vaccine (MMR or equivalent vaccine) given at least 4 weeks apart on, or after their first birthday: Date of Vaccine # 1: _____ Date of Vaccine # 2: _____ **<u>OR</u>** Indicate you are providing laboratory evidence of Mumps immunity ☐ (Attach paperwork that shows positive titre).
Step 5) Two doses of Varicella (chickenpox) vaccine given at least 4 weeks apart?	**Yes** ☐ **No** ☐	**If yes,** document the relevant dates of <u>two doses</u> of Varicella vaccine given at least 4 weeks apart. Date of Vaccine #1: _____ Date of Vaccine #2: _____ **<u>OR</u>** Indicate you are providing laboratory evidence of Varicella immunity ☐ (Attach paperwork that shows positive titre).

Step 6) Tuberculosis (TB) status is also a <u>mandatory</u> requirement.

Everyone requires a two-step TB test.

- If your patient has ever had a two-step TB test in the past, provide documentation below. If this two-step was completed over one year ago, an additional one-step TB skin test is required.
- If there is evidence of a two-step TB test completed within the past year, further TB skin testing is not needed.

The protocol advises that persons previously receiving BCG vaccine but not known to be tuberculin positive, should be similarly tested. Tuberculin positive persons who have never been previously evaluated should be sent for a chest x-ray.

BCG History: Yes ☐ No ☐

<u>TB Skin Test Protocol:</u> An initial skin test (5TU PPD) is given. If it is negative (**less than 10 mm induration**) 48-72 hours later, a 2nd test is given in the opposite arm at least one week, and no more than three weeks, after the first. The 2nd test must be read within 48-72 hours. The results of the 2nd test should be used as the baseline test in determining any necessary treatment and follow-up.

Please document evidence of all required TB skin tests below:		**Results:**
Two-Step TB skin test	Date of 1st skin test: _____ Date of 2nd skin test: (if 1st skin test is negative) _____ ****Negative = less than 10 mm induration**	Negative _____ mm induration Positive _____ mm induration Signature of MD/RN/RPN:_____ Negative _____ mm induration Positive _____ mm induration Signature of MD/RN/RPN:_____
Additional One-Step (to be up-to-date)	Date of skin test: _____ ****Negative = less than 10 mm induration**	Negative _____ mm induration Positive _____ mm induration Signature of MD/RN/RPN:_____

Chest X-Ray date/result, if positive TB skin test: _____

(Please attach documentation of Chest-X-Ray results)

Name of Learner/applicant:_____

Has your patient received these *Recommended* vaccines?:

Step 7) Hepatitis B vaccination series?	**Yes** ☐ **No** ☐	**Immune** ☐ **Not immune** ☐ Laboratory evidence of immunity attached? **Yes** ☐ **No** ☐
Step 8) Tetanus Diphtheria Acellular Pertussis Vaccine (Tdap)? **All persons carrying out hospital activities, who have not received an adolescent or adult dose of Tdap, should receive a single dose of Tdap at their next tetanus booster.	**Yes** ☐ **No** ☐	Name of Vaccine: _____ Date: _____
Step 9) Seasonal Flu vaccine given during flu season?	**Yes** ☐ **No** ☐	Name of Vaccine: _____ Date: _____

The information on pages 1, 2 & 3 has been provided by the applicant's Health Care Provider. Yes ☐ **No** ☐

Signature of MD/RN/RPN:
_____

Name (printed) of MD/RN/RPN:
_____

Date: _____

Name of person completing this form if **not** the Health Care Provider: _____

~For Office Use Only~

Hamilton Health Sciences Clearance Provided by Employee Health Services

Signature of RN/RPN: _____
Name (printed) of RN/RPN: _____

This individual is considered: Fit ☐ Fit with Restriction ☐ Date: _____
Notes: _____
_____
_____

Clearance e-mailed: Yes ☐ No ☐

May 2017