Regions Hospital
HealthPartners
*Employee Health & Wellness*
Ph: 651-254-3301 FAX: 651-254-2446
E-mail: regionsemployeehealthwellness@healthpartners.com

Please Print:

Name: ______________________________

Birthdate: ____________ Phone Number: ____________

Email: ______________________________

# Volunteer Services - Initial Screening Tuberculosis and Immunization History

INSTRUCTIONS: COMPLETE THE VOLUNTEER SECTIONS OF FORM *(FRONT AND BACK)* BEFORE YOUR SCREENING.

**Review of Vaccination & Disease History** (Review of medical information is required before you begin volunteering.)
**Very Important:** Bring copies of all your immunization records; including disease history, vaccination dates, blood test results showing immune status (titer).

**Your healthcare provider (Doctor, Nurse Practitioner, Physician Assistant) must sign-off on immunization records.**

| **VOLUNTEER SECTION - Enter your immunization dates and/or disease history for:** | | | | |
|---|---|---|---|---|
| **Tdap** | Date: / / | | | |
| **Influenza** | Date: / / | | | |
| **Covid Vaccine** | Manufacture :____________<br>Date of dose #1 : / / Date of dose #2: / / | | | |
| **Chicken Pox** (Varicella)<br>**2 doses after first birthday* | ☐ Vaccinated | Date of Dose #1: / / | Date of Dose #2: / / | |
| | ☐ Titer Drawn | Date: / / | ☐ Immune per titer/blood test | Result Date: / / |
| **Measles** (Rubeola) (MMR)<br>**2 doses after first birthday* | ☐ Vaccinated | Date of Dose #1: / / | Date of Dose #2: / / | |
| | ☐ Titer Drawn | Date: / / | ☐ Immune per titer/blood test | Result Date: / / |
| **Mumps** (MMR)<br>**2 doses after first birthday* | ☐ Vaccinated | Date of Dose #1: / / | Date of Dose #2: / / | |
| | ☐ Titer Drawn | Date: / / | ☐ Immune per titer/blood test | Result Date: / / |
| **Rubella** (MMR)<br>**2 doses after first birthday* | ☐ Vaccinated | Date of Dose #1: / / | Date of Dose #2: / / | |
| | ☐ Titer Drawn | Date: / / | ☐ Immune per titer/blood test | Result Date: / / |

**I have verified the information provided by the volunteer on the front & back of this form is accurate & complete.**

**Attending Provider Signature:** ______________________________ **Date:** ________________

**Printed Name & Credentials:** ________________________ **Office/Clinic:** ________________

| **Sections Below To Be Completed by Employee Health and Wellness Nurse** | | | |
|---|---|---|---|
| Tetanus, Diphtheria, Pertussis (Tdap) | ☐ Meets Requirement | ☐ Vaccinated—See VAR | |
| Influenza (October 1-March 31) | ☐ Meets Requirement | ☐ Vaccinated—See VAR | |
| Chicken Pox (Varicella) | ☐ Meets Requirement | ☐ Vaccinated—See VAR | ☐ Titer Drawn |
| German Measles (Rubeola) (MMR) | ☐ Meets Requirement | ☐ Vaccinated—See VAR | ☐ Titer Drawn |
| Mumps (MMR) | ☐ Meets Requirement | ☐ Vaccinated—See VAR | ☐ Titer Drawn |
| Rubella (MMR) | ☐ Meets Requirement | ☐ Vaccinated—See VAR | ☐ Titer Drawn |

**PLEASE COMPLETE BOTH SIDES OF FORM**

**Tuberculosis (TB) Screening** (TB Screening is required before you begin volunteering.)

**VOLUNTEER SECTION - Answer all questions in this box:**

1. Check any symptoms you currently have and have had for more than three weeks:
   ☐Persistent cough ☐Excessive Fatigue ☐Hoarseness ☐ Coughing up blood
   ☐Excessive weight loss ☐ Excessive sweating at night ☐ Persistent fever
2. Were you born outside of the U.S.A.?
   ☐No ☐Yes: Country of birth ________________ Year you moved to the U.S.A. ___________
3. Have you traveled or lived outside of the U.S.A.?
   ☐No ☐Yes: Where and for how long? __________________________________________
4. Have you ever been exposed to or lived with a person diagnosed with and/or treated for TB?
   ☐No ☐Yes: When __________________________
5. Do you work or volunteer in a group home, prison, or homeless shelter?
   ☐No ☐Yes: Where __________________________
6. Has a health provider told you that your immune system is not working or cannot fight infection?
   ☐No ☐Yes ☐Do not know
7. Have you ever received the BCG Vaccine?
   ☐No ☐Yes ☐Do not know
8. Have you ever had a TB skin test (also known as Mantoux, PPD, or TST)?
   ☐No ☐Do not know ☐Yes: Date of last test ____________ Result ___________
9. Have you ever had a TB Blood Test (such as Quantiferon Gold or Q-Gold)?
   ☐No ☐Do not know ☐Yes: Date of last test ____________ Result ___________
10. Have you ever had a chest x-ray for TB?
    ☐No ☐Yes: Date __________ Result (bring copy) ☐ Normal ☐Positive for TB ☐Other
11. Have you ever been treated for TB or Latent TB?
    ☐No ☐Do not know ☐Yes: Medication ☐ Isoniazid (INH) ☐ Other__________________
    Year you started treatment: ___________ How long did you take the medication? _______months
    When was your last dose? ____________

**Sections Below To Be Completed by Employee Health and Wellness Nurse**

Is volunteer a Minor? ☐No ☐Yes - verify parent or guardian is present and initial here: _____________

Has volunteer had a live virus vaccine within the last 6 weeks? ☐No ☐Yes

Has volunteer had a severe viral illness in the past 6 weeks? ☐No ☐Yes

Is TB Blood test contraindicated? ☐No-order Lab ☐Yes – consult with program coordinator/lead RN

☐**TB Blood Test Ordered** Date: ________________Result: _______________ Result Date:_______________

☐**Additional evaluation required: Chest X-ray Ordered** Date: ________________Result: _________________

☐ **Reviewed by EHW RN** & **Referred to PCP** with form & copy of records: Referral Date: _______________

| ☐ Documented final clearance in Midas.<br>RN Initials: Date: | ☐ Final clearance emailed to Volunteer Services<br>RN Initials: Date: |
|---|---|

# PLEASE COMPLETE BOTH SIDES OF FORM