childrenshealth

Health Form and Immunization Requirements

Thank you for your interest in completing your rotation at Children's Health. For your safety and the safety of our patients, we require that you meet all occupational health requirements outlined in this document. Please be advised that Children's Health does not provide immunizations for students.

You are required to provide appropriate documentation for ONLY one of the outlined options for each requirement below. Complete the Health Form and submit both the Health Form and all required immunization records to OHStudents@Childrens.com.

Tuberculosis (TB) Test: *(Test is required annually and must be current through entire rotation)*

Option 1: TB blood test (one of the following)

- Quantiferon Gold TB
- T-SPOT blood test

Option 2: Evidence of 2 Mantoux tuberculin skin tests (TST) within the same year.
An acceptable form of documentation should include both the date applied, date read, measurement and signed by a medical professional.

Option 3: Students with a past positive TB test must provide positive test result (PPD with measurement or QFT), a two-view chest x-ray and documentation from a provider stating student is free from disease within the last year.

Varicella (chickenpox)

Option 1: Two documented doses of varicella vaccine

Option 2: Positive titer for varicella

Measles, Mumps and Rubella (MMR)

Option 1: Two documented doses of measles, mumps, rubella (MMR)vaccine

Option 2: Positive titer for measles, mumps, rubella (MMR) vaccine

Tetanus, Diphtheria (Td) or Tetanus, Diphtheria and Pertussis (Tdap)

Option 1: Documentation of Tdap given on/after age 11yrs and either Tdap or Td within the last 10 years

Influenza *(required during flu season only)*

Option 1: Documentation of either injectable or nasal flu vaccine

Option 2: Not applicable – Rotation does not fall within flu season which is typically September through May but may vary year to -year.

COVID-19

- The COVID-19 vaccine is not a requirement for applicants at Children's Health. If you have received the COVID-19 vaccinations, please submit your records so that they are on file (proof of both doses of a two-dose series or proof of a single dose vaccine and/or booster).

Hepatitis B *(Recommended for any health care personnel HCP in clinical setting)*

Option 1: Documentation full hepatitis B vaccine series

Option 2: Documentation of a positive hepatitis B titer

Option 3: Currently receiving hepatitis B series

Option 4: NOT assigned to a clinical area during rotation

NAME: ______________________________ EMAIL: ______________________________

PHONE #: ____________________ SCHOOL/COMPANY: ______________________________

HOSTING DEPARTMENT: ______________________________ ROTATION END DATE: ____________________

HEALTH FORM- (REQUIRED FOR FACULTY, STUDENTS & CONTRACT STAFF)

Full documentation is required for all the following requested records

1. Tuberculosis (TB) TESTING

Option 1	QFT, IGRA or T-spot (MM/YY):	Results:
Option 2 Student must show evidence of 2 skin tests within the same year.	TB Skin Test 1 Date (MM/DD/YY):	Results:
	TB Skin Test 2 Date (MM/DD/YY):	Results:

If you must receive any immunizations, you should complete your TB testing prior to receiving your vaccinations.

2. VARICELLA (aka Chickenpox)

Option 1	Two doses of Varicella	Varicella 1	Date:
		Varicella 2	Date:
Option 2	Blood titer (test) confirming Varicella immunity	Results:	Date:

3. MEASLES, MUMPS AND RUBELLA (MMR)

Option 1	Please list the following:	Measles Immunization	Date:
		Mumps Immunization	Date:
		Rubella Immunization	Date:
		MMR Immunization Booster	Date:
Option 2	Or provide the dates of two Measles, Mumps and Rubella (MMR) immunizations:	MMR Immunization 1	Date:
		MMR Immunization 2	Date:
Option 3	Or provide blood titer (test) confirming Measles, Mumps and Rubella immunity	Measles Titer Results:	Date:
		Mumps Titer Results:	Date:
		Rubella Titer Results:	Date:

4. TETANUS, DIPHTHERIA, PERTUSSIS (Tdap) and/or TETANUS DIPHTHERIA (Td) (Must have one Tdap and must have had Td or Tdap with last 10 years)

Option 1	Tdap after on/after age 11yrs of age AND Td or Tdap within last 10yrs	Tdap Date:	Td Date:

5. INFLUENZA IMMUNIZATION ***(Injection or Mist)***

Option 1	Influenza Injection Date (MM/YY):	Influenza Mist Date (MM/YY):
Option 2	Not Applicable – rotation NOT during flu season *(flu season typically September-March)*	Hosting Department:

6. COVID-19 (Not currently required, but if received, please list dates)

Option	Vaccine	Date
Option 1 *Two dose series*	Vaccine1	Date:
	Vaccine 2	Date:
Option 2 *1 dose series*	Vaccine1	Date:
Option 3 *WHO approved vaccine*	Vaccine 1	Date:
	Vaccine 1	Date:
COVID-19 Booster	Booster	Date:

7. CLINICAL ROTATION ONLY - HEPATITS B VACCINE

Option	Vaccine	Date
Option 1 *Two or three dose series*	Vaccine1	Date:
	Vaccine 2	Date:
	Vaccine 3 (if applicable)	Date:
Option 2	Positive Titer	Date: Results:
Option 3	Not Applicable – rotation NOT in a clinical area	Hosting Department:

***Please ensure all documents are legible and are acceptable forms of documentation. See additional details below.**

<u>Acceptable forms of documentation include:</u>

- Immunization records from a physician's office, medical clinic, health department
  - Must include student's name, date of birth (DOB), date of vaccine administration, manufacturer

<u>Examples of records NOT accepted as proof of immunization:</u>

- A school's Nursing Immunization Form, even if it has been signed off by a physician
- The University's Health Record
- A receipt for a vaccination

ANNUAL TUBERCULOSIS EVALUATION

Name:			Date of Birth:	
Preferred Email Address:			Preferred Phone Number:	
☐ Employee	☐ Medical Staff	☐ Med Educ.	☐ Volunteer	☐ Student
CMC Employees including APN's ID# _______________	Attending MD, Dental, Allied Health ID# _______________	Fellow, Resident, Rotating Resident ID# _____________	Annual, 1st year, pastoral care ID# _______________	Traveler, Other Title: ___________ ID# _____________

In the past year, have you:		
Is your primary department the Emergency Department?	☐ YES	☐ NO
Are you a resident, fellow or medical student?	☐ YES	☐ NO
Had a known exposure to TB and were ***not*** wearing a mask	☐ YES	☐ NO
Diagnosis of Pneumocystis Carinii Pneumonia	☐ YES	☐ NO
Diagnosis of being immune compromised	☐ YES	☐ NO
Current or planned immunosuppression (including HIV, receipt of an organ transplant, treatment with a TNF- alpha agonist, chronic steroids, or other immunosuppressive medication	☐ YES	☐ NO
Cough lasting longer than three weeks	☐ YES	☐ NO
Loss of appetite	☐ YES	☐ NO
Unexplained weight loss	☐ YES	☐ NO
Profuse night sweats	☐ YES	☐ NO
Fatigue (unusual tiredness)	☐ YES	☐ NO
Coughing up blood	☐ YES	☐ NO
Chills, sweats and/or fever >100.0 without alternative etiology	☐ YES	☐ NO
Chest pain	☐ YES	☐ NO
Difficulty breathing	☐ YES	☐ NO
Volunteered in a homeless shelter or jail	☐ YES	☐ NO
Had visitors from a foreign country stay with you	☐ YES	☐ NO
Temporary or permanent residence (for >1 month) in a country with a high rate of TB (ie: any country other than Australia, Canada, New Zealand, US and those in western/northern Europe)	☐ YES	☐ NO
Had close contact with someone who has infectious TB disease since your last TB test	☐ YES	☐ NO
If you answered yes to any of the above, please explain:		

Travel outside the United States in the last 12 months:

☐ I have not traveled outside the U.S. in the past 12 months

☐ Dates of Travel:____

☐ Locations: ____

☐ Duration of trip: ____

Have you ever had a positive TB Test?

☐ NO ☐ Yes, I had a positive Skin Test on _________ (Year) OR ☐ Yes, I had a positive TB Blood Test on ___________ (Year)

Did you have a chest x-ray completed and reviewed by a radiologist? ☐ YES ☐ NO

Did you receive LTBI Treatment? ☐ No ☐ If yes, please describe:

TB Respirator N95 Mask (if yes, consider retesting)		
Any changes in facial structure such as jaw surgery, facial hair, new eyeglasses, etc.	☐ YES	☐NO
Weight gain or loss of 15 pounds or more?	☐ YES	☐NO

_______________________________________ _______________

Your Signature Date