**HEALTH REVIEW FORM**

 🞏 Paid Staff 🞎 Private Hire

🞏 St. Joseph’s 🞏 Mt. Hope 🞏 Parkwood Institute Main Building 🞏 Parkwood Institute Mental Health Care 🞏 Southwest Centre

**In order to fulfill the terms and conditions of your employment offer, the following information must be provided to Occupational Health and Safety Services no later than 7 business days prior to your start date. Incomplete forms and late submissions WILL delay your start date.**

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.

Fill in the immunization dates below, as noted on your yellow immunization cards. Send a copy of the yellow immunization card along with this form. If you don’t have your own records, take this form to your physician or Public Health Unit to complete in full and sign. Relatives are not permitted to complete and sign this record. **Once completed and signed, scan form and email to:** **OHSS@sjhc.london.on.ca** **or fax to 519-646-6235.**Any costs associated with the completion of this form are your responsibility. Retain a copy for your records.

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| LAST NAME | FIRST NAME | MIDDLE INITIAL |
| ADDRESS  |
| PRIMARY PHONE #(May be home or cell) | EMAIL (OPTIONAL) |
| COUNTRY OF BIRTH  | DATE OF BIRTH |
| FAMILY PHYSICIAN | EMERGENCY CONTACT PERSON | EMERGENCY CONTACT #  |
| JOB TITLE | DEPARTMENT | COORDINATOR/ DIRECTOR: |

**TUBERCULOSIS**

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| **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: |

**Required Immunizations**

|  |  |  |  |
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| **Measles:** | Laboratory evidence of immunity (titres), **OR** | Date of test: | Result: 🞏 Immune 🞏 Not Immune |
| 2 doses of measles-containing vaccine on orafter the first birthday, with doses given at least four weeks apart, | Date of 1st MMR: | Date of 2nd MMR:  |
| **Mumps:** | Laboratory evidence of immunity (titres), **OR** | Date of test: | Result: 🞏 Immune 🞏 Not Immune |
| 2 doses of mumps-containing vaccinegiven at least four weeks apart on or after the first birthday | Date of 1st MMR: | Date of 2nd MMR: |
| **Rubella:** | Laboratory evidence of immunity (titres), **OR** | Date of test: | Result: 🞏 Immune 🞏 Not Immune |
| Evidence of immunization with live rubella containing vaccine (one dose) on or after their first birthday | Date of MMR: |
| **Varicella:** | Varicella vaccine (2 doses required), **OR** | Date of 1st dose: | Date of 2nd dose: |
| Laboratory evidence of immunity (titres), **OR** | Date of test: | Result: 🞏 Immune 🞏 Not Immune |
| Laboratory evidence of chickenpox or shingles (from lesion swab or scraping) | Date of test: | Result: 🞏 Varicella-zoster virus detected |

|  |  |  |  |
| --- | --- | --- | --- |
| **Hepatitis B:** | Confirmatory titre test result if available  |  Received vaccine? 🞏 Yes 🞏 No | Date of titre test:Result of titre test: 🞏 Immune  🞏 Not Immune 🞎 Not tested  |
| Vaccination is **highly recommended** for Staff who may have exposure to human blood and body fluids. **Hep B is not mandatory for volunteers.**  | Date of 1st doseDate of 2nd doseDate of 3rd dose |
| **Tetanus/****Diphtheria/****Pertussis:** | Tdap **is recommended** for all adults Tetanus and Diphtheria is recommended every 10 yearsPertussis- once in adulthood | 🞏 Tdap Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If never received Tdap 🞏 Td Year of most recent booster: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Influenza:** | Highly recommended each year | Date of most recent vaccine: |

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| --- | --- |
| Have you been fit-tested within the last 2 years to wear an N95 respirator? | ⬜ Yes ⬜ NoIf Yes, attach proof. |

Do you have any food/drug allergies or any emergent medical conditions (eg, asthma, epilepsy, diabetes, heart condition) that you feel Occupational Health should be aware of? **🞎** Yes **🞎** No

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Do you have a disability that requires an accommodation? **🞎** Yes **🞎** No

(If yes, provide details) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician contact Information and signature required if form was completed by the Physician.**

Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 PRINT NAME

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**For Staff/Private Hire**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to release the above information to Occupational Health and Safety at

St Joseph’s Health Care London.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRINT NAME

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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