Volunteer Health Review Form

Section A: Health History

To be completed and signed by the volunteer.

Start Date:

First Name:

Middle Initial:

Last Name:

Date of Birth:

Sex:

Phone Number:

Email Address:

Home Address:

Volunteer Resource Associate:

Site:

- ☐ University Hospital (UH)
- ☐ Victoria Hospital (VH)
- ☐ Other

Emergency Contact Person:

Contact Number:

Pertinent health information:

Do you have any allergies or health conditions that you feel Occupational Health & Safety? Services should be aware of? If yes, provide details below.

I acknowledge that the information provided on this form is true and complete. I understand that all medical information provided is confidential, and shall not be released to any source internally or externally without my consent. I understand that Occupational Health & Safety Services will maintain my health information and will comply with the LHSC Confidentiality Policy.

Volunteer's Signature:

Date:

Section B: Immunization & Status of Immunity

Complete and **provide documentation** to support immunization and immunity. Review the instructions prior to completing this section.

Full Name:

Date of Birth:

Required vaccinations/proof of immunity

TB Skin Test

Refer to the instructions on Page 2. A Positive TB skin Test is > 10 mm of induration

Test	Date Planted	Date Read	Result (Positive/Negative	Level of Induration (mm) - Required
1st Step				
2nd Step				
Annual (if required)				

MMR Vaccination or Evidence of Immunity

If full series provided, evidence of immunity not required.

Vaccine	Date	Immune (Yes/No)
MMR Vaccine # 1		
MMR Vaccine #2		
Measles Serology		
Mumps Serology		
Rubella Serology		

Measles, Mumps and Rubella administered separately (attach document with dates).

VARICELLA Vaccination or Evidence of Immunity

If full series completed evidence of immunity not required

Vaccine	Date	Immune (Yes/No)
Varicella 1		
Varicella 2		
Varicella Serology		

Volunteer Signature:

Date:

Health Care Provider Signature:

(Health Care Provider signature only required if a licensed physician/nurse practitioner is attesting to immunization/immunity without forwarding supporting documentation)

Section C: Tuberculosis (TB) Questionnaire

To be completed **only** by those who have recently or historically had a **positive TB skin test.**

LHSC follows the Canadian Tuberculosis Guidelines and Public Health Ontario guidance for all staff with a positive TB skin test. A positive TB Skin Test occurs following exposure to TB, during active TB, or because of BCG vaccination. The information you provide on this form will assist Occupational Health Services (OHS) to determine the reason for your positive result, the need for further investigation, or the benefit of additional medical assessment. OHS will provide additional health teaching resources or schedule an appointment with the OHSS Nurse Practitioner.

Name:

Employee ID:

Position:

Age:

Positive TB Skin Test

Date Planted:

Date Read:

Level of Induration:

Chest X-Ray

A Chest X-Ray is required following the date the TB skin test was read. Please attach a copy of the X-ray Report.

Date of Chest X-ray:

Result (Normal/Abnormal):

Have you ever had abnormal findings on a chest X-ray relating to TB?

- ☐ Yes (If yes, include findings)
- ☐ No

BCG Vaccination

Have you received BCG vaccination?

- ☐ Yes
- ☐ No

If yes, please provide the date(s) you received this vaccination:

- ☐ Less than 2 years of age
- ☐ 2 years of age or older

In what country did you receive this vaccination?

History

History of active TB disease

- [ ] Yes
- [ ] No

Unprotected TB exposures in the previous year

- [ ] Yes
- [ ] No

History of symptoms of active TB in the previous year:

- [ ] Yes
- [ ] No

If yes, what symptoms have you experienced?

- [ ] Productive Cough
- [ ] Loss of Appetite
- [ ] Fever
- [ ] Chest Pain
- [ ] Unexplained Weight Loss
- [ ] Fatigue
- [ ] Coughing Up Blood
- [ ] Night Sweats

Immigration and Travel

Country of Birth:

Country and state/province/territory (if applicable) from which you immigrated to Canada:

Date of Immigration to Canada:

Age at Immigration:

Have you lived in any other countries?

☐ Yes (If yes, please specify where and the dates)

☐ No

Have you travelled to any TB-endemic countries?

☐ Yes (If yes, please specify where and the dates)

☐ No

Medical Follow Up

Have you consulted with a medical practitioner or Infectious Diseases Specialist about your positive TB Skin test?

☐ Yes (Attach documents if available)

☐ No

Have you had an IGRA or QuantiFERON-TB GOLD test?

☐ Yes (Attach result)

Result: ○ Negative ○ Positive

Date of test:

☐ No

Have you been treated for Latent TB Infection (LTBI)?

☐ Yes. If yes please specify the medication, length of treatment and the date completed.

☐ No

Important Information

A TB Skin Test is considered positive if the level of induration (firm swelling) is ≥ 10 mm, or ≥ 5mm if the following criteria are met:

1. HIV infection
2. Contact with infectious TB in the past 2 years
3. Fibronodular disease on chest X-ray
4. Organ transplant
5. TNF alpha inhibitors
6. Treatment with immunosuppressive drugs (equivalent to 15 mg/day of Prednisone for 1 month or more)
7. End-stage renal disease

Volunteer Signature:

Date: