London Health Sciences Centre

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:

Telephone:

Volunteer resource associate:

Site:

Email address:

Home address:

Emergency contact person:

Contact telephone 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

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

MMR Vaccine #1:

MMR Vaccine #2:

Measles Serology:

Mumps Serology:

Rubella Serology:

VARICELLA Vaccination or Evidence of Immunity

(If full series completed evidence of immunity not required)

	Date	Immune Yes/No
Varicella 1		
Varicella 2		
Varicella Serology		

COVID-19 Vaccination

Proof of vaccination with QR Code Required

	Brand Name	Date:
COVID 19 #1		
COVID 19 #2		
COVID-19 XBB vaccination		

Health Care Provider Signature (Required only if a licensed physician/nurse practitioner is attesting to immunization/immunity without forwarding supporting documentation; does not pertain to COVID 19 vaccinations which require proof)

Signature:

Date:

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 Ontario Hospital Association (OHA) Tuberculosis Surveillance Protocol for all staff and volunteers with a positive TB skin test. A positive TB Skin Test occurs following exposure to TB, during active TB, or as a result of BCG vaccination. The information you provide on this form will assist Occupational Health & Safety Services (OHSS) to determine the reason for your positive result, the need for further investigation, or the benefit of additional medical assessment. OHSS will provide additional health teaching resources, or schedule an appointment with the OHSS Nurse Practitioner.

Name:

Position:

Age:

Positive TB Skin Test

Date Planted:

Date Read:

Level of Induration:

Location Test was Administered:

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:
Have you ever had abnormal findings on a chest X-ray relating to TB? If yes, please include the findings below.

Findings:

BCG Vaccination

Have you received BCG vaccination?

Date(s):

< 2 years of age ☐

> 2 years of age ☐

In what country did you receive this vaccination?

History

History of active TB disease

Unprotected TB exposures in previous year

History of symptoms of active TB in previous year:

If yes, what symptoms have you experienced?

☐ Productive Cough

☐ Unexplained Weight loss

☐ Loss of Appetite

☐ Fatigue

☐ Fever

☐ Cough up blood

☐ Chest Pain

☐ 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 traveled to any TB endemic countries?

(If Yes) Where:

(If Yes) Date:

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:

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

Medical Follow Up

Have you consulted with a medical practitioner or Infectious Diseases Specialist about your positive TB Skin test? If yes, attach documentation if available.

Have you had an IGRA or QuantiFERON-TB GOLD test? If yes, attach result.

Result:

Date of Test:

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

(If Yes) Medication:

(If Yes) Length of Treatment:

(If Yes) Date completed: