St. Mary's General Hospital

350 Boulevard▪Passaic, NJ▪07055

Employee Health Services

Volunteer: Tuberculosis, Measles, Rubella, Varicella and Hepatitis B Screening

Dear Applicant,

Please note that the form Health Certificate must be presented to your physician for the physical exam. It requests an evaluation for i**mmunity** status for Measles, Rubella, Varicella and Hepatitis B. Proof of Hepatitis B immunity may be established via a titer or date of when 3 vaccine doses where given.

NJDHSS, NJHA, CDC require all hospital healthcare workers and volunteers to be screened for Tuberculosis and other diseases.

The initial **two-step** (two doses, one week apart) PPD/Tuberculin Skin Test for Tuberculosis may be done with your private physician, or at St. Mary's General Hospital Nursing HUB Department, Monday – Friday, 9:00 a.m. – 6:30 p.m. and Saturday – Sunday, 9:00 a.m. – 5:00 p.m. The HUB is located on the 2nd floor of the Main Building, (turn left when exiting the elevator on the 2nd floor). **Please bring this form and your entire Volunteer Application with you when reporting to the HUB for this TB skin test.** There is no fee for this PPD test.

**** Parent or legal guardian of minors must be present for placement of TB skin test ****

The skin test will be placed /injected on the forearm just under the first layer of skin (intradermal) and must be read 48 hours - 72 hours after. Tuberculin skin tests may be read by a registered nurse in the HUB, a school nurse or a private physician. If the test is administered by St. Mary's, we will provide the form for documentation of off- site readings.

Allergy to eggs or taking large doses of Prednisone must be reported to the HUB.

If the applicant has had a negative PPD/Mantoux/Tuberculin skin test within the last 12 months, then please submit the documentation for review. The second one may be given at the St. Mary's Nursing HUB. .

If the applicant has a ***past history*** of a positive skin test (that of an induration greater than 10mm), documentation of a medical evaluation and ***treatment plan*** will be requested. A copy of a current chest-x-ray report by a radiologist should also be submitted for review but is not enough by itself. The treatment plan must be documented regardless of declining or accepting treatment. Please bring any past documentation for review to the HUB and/or submit it with your Volunteer Application.

New positives will be followed up as per St. Mary's General Hospital Policy.

I hereby give permission for Tuberculosis skin testing/ screening for:
Parent or legal guardian must be present for placement of Tb skin test

Volunteer's Name: ____

Name of parent /legal Guardian (Print): ______________________________________

Signature of parent/legal guardian ______________________________ Date____/____/____

Any questions about this test, may be directed to HUB nursing personnel at 973-365-4379.

BRING THIS FORM TO YOUR DOCTOR

St. Mary's General Hospital

Volunteer Department

HEALTH CERTIFICATE

Volunteer Applicant Name: ______________________________ **SS#:**_____________________
(Last, First, MI)

Address: ____
(Street, City, State, Zip)

Telephone Number: (_____) ____________________ **DOB:** _______/_______/________

1. **Measles, Mumps, Rubella, and Varicella:** The CDC defines immunity to these viruses as one of the following: (1) Appropriate immunization*, (2) positive titer, diagnosed case of the illness. Given the above definition of immunity, please complete the following information for this individual.

VACCINE:	Dates of each injection or exposure.				
Measles:	Yes_____	No_____	Mumps:	Yes_____	No_____
Rubella:	Yes_____	No_____	Varicella:	Yes_____	No_____

*Measles, Mumps, and Rubella Vaccine (MMR): Two doses of live measles (or MMR) vaccine, at least one month apart, on or after his/her first birthday. Varicella Vaccine: Individuals who receive the vaccine between 12 months and 12 years of age are required to only receive one dose of the vaccine. Individuals over the age of 13 should receive two doses of the vaccine 4 to 8 weeks apart. If unsure of immune status, please have titers done.

2. **Hepatitis B Vaccine:** If you have given this patient the Hepatitis B vaccine, please record the dates that it was given.

1st dose _____/_____/_____ 2nd dose_____/______/_____ 3rd dose_____/_____/_____

3. **Tuberculosis Testing:** If you have ever placed a Mantoux Test (PPD) on this patient, please record the two most current test dates and results. If positive, please provide documentation of a chest x-ray.

Date: mo/date/yr Amount Result (mm)

1.____

2.____

4. **Health Status:** To my knowledge this applicant:

a. Is free from contagious disease and capable of performing all volunteer assignments.

Yes______ **No**______

b. If no, please list what precautions need to be taken and if the volunteer has any restrictions in her or his activities:

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5. **Doctor's Name:** __________________________ **Doctor's Signature**: ______________________

6. **Doctor's Address**: ____