Employee Health Department

REQUIREMENTS

PLEASE READ AND FOLLOW THESE INSTRUCTIONS CAREFULLY!

Complete the Infectious Disease Summary and provide **official supporting documentation** of the following:

- Documentation of MMR I and II (date) OR documentation of positive Rubella, Rubeola, and Mumps titers (blood test)
- Documentation of 2 Varicella immunizations OR documentation of a positive Varicella titer (blood test)
- Date and result of any TB skin tests received within the past 2 years
- Date of last Tdap (Tetanus, Diptheria, Pertussis) vaccination
- Documentation of the Hepatitis B immunization series

NOTE: The immunization information may be obtained from your health care provider’s office. Information must be received by Employee Health at orientation. If not submitted you will be required to have blood work drawn at the employee health initial health screen.

*By regulation, employee health records and your personal medical records are maintained separately.*
Employee Health Department
INFECTIONOUS DISEASE SUMMARY

***Complete the Infectious Disease Summary AND provide official supporting documentation of immunizations from your medical provider and/or healthcare institution

Name: ____________________________
Phone Number: ______________________
Date of Birth: ___/___/___
Department: _______ Job Title: ____________

Address: ____________________________
City: __________________ State: ______
Zip Code: __________
Emergency Contact: _______________________
Phone Number: ______________________

TUBERCULOSIS STATUS: (Most recent)
TB Skin Test
Administered ___/___/___ Read ___/___/___
Results: Negative__________
Positive__________ mm
TB Skin Test
Administered ___/___/___ Read ___/___/___
Results: Negative__________
Positive__________ mm
IF HISTORY OF POSITIVE TB TEST
Provide copy of most recent Chest X-ray report and provide any additional medical treatment received.

IMMUNIZATIONS:

Tetanus, Diphtheria, Pertussis (TDAP)
Date: ___/___/___

Hepatitis B - Dates
(1) ___/___/___
(2) ___/___/___
(3) ___/___/___
(Optional) Hepatitis B titer
Date/Result_________________

Varicella (Chicken Pox)
Two Doses of Vaccine
(1) ___/___/___
(2) ___/___/___
OR
Positive Antibody Titer by Lab Screen
Rubella Date: ___/___/___
Rubeola Date: ___/___/___
Mumps Date: ___/___/___
If any of the Titers are Negative
Vaccination is needed

History of Varicella is not accepted

Signature of Medical Provider: ____________________________ Date: ___/___/___
Address: ____________________________ City: __________________ State: ___ Zip Code: ______

Signature of Employee________________________________ Date: ___/___/___