Special Category Volunteer Medical Packet

Name:_____ Date of Birth:_____

Hospital policy mandates that each volunteer meets specific health requirements, including all information listed in this packet.

Please use this checklist to help ensure that you have all of the health requirements completed before you submit this packet to Occupational Health. Please review the specified details for each requirement on page 2 of this packet.

- ☐ This completed checklist (page 1)
- ☐ Volunteer medical history form (page 3)
- ☐ Volunteer signature (and parent/guardian signature for minors) (page 4)
- ☐ Evidence of tuberculosis screening (pages 4-5)
- ☐ MMR titer results or immunization record (pages 5-6)
- ☐ Varicella titer results or immunization record (pages 5-6)
- ☐ TDAP vaccine record (pages 5-6)
- ☐ Flu vaccine record (during flu season only –pages 5-6)
- ☐ A health screening from your physician (page 6)

Please email your packet with attached immunization records/titer results to ohvolunteers@childrensnational.org in one email once completed. Thank you!

Explanation of Medical Requirements and Procedures
Special Category Volunteers

Occupational Health requires all volunteers to complete the following medical forms. This document serves as an overview of the medical clearance process. Specific questions regarding individual medical forms may be directed to the Children's National Occupational Health Department via email. Other more general inquiries may be directed to Volunteer Services.

The first medical form, the Employee/Volunteer Medical History, is a simple health questionnaire volunteers should complete; questions about personal and familial medical history are included.
The second medical form, the Volunteer Medical Form, is a comprehensive medical form that is divided into five parts or requirements.

- The volunteer shall provide evidence of health screening and proof of immunity by providing immunization records to vaccine-preventable diseases as required by Occupational Health.
- Medical clearance must be validated by an outside practitioner.
- All documents must be translated into English. Please email all documents to **ohvolunteers@childrensnational.org**
- Hours for document review between 7-10 am or 1-3:30pm.

***Requirement 1*:**
Tuberculosis Screening requirements
1. Each NEW volunteer must have TWO skin tests (PPD's). After each skin test is administered, the recipient must return within 48 to 72 hours to have the result read and recorded on this sheet. There must be at least seven days in between the placement of the first PPD and the placement of the second PPD. The second PPD must fall before the health screen in the same month.
2. Or you may show evidence of a recent (within 12 months of application) Quantiferon or T-Spot lab test.
3. PPD positive volunteer applicants must provide chest x-ray reading result (within 12 months of application).

**To ensure that the volunteer is free from Tuberculosis the volunteer must have a biennial health screen (completion of medical update form and placement/reading of Tuberculosis skin test (PPD)).

***Requirement 2*:**
Immunization Requirements

- Each volunteer must submit documentation of proof of immunity to chicken pox, Tdap, measles, mumps, and rubella, and current flu vaccine during the season.
- The two acceptable forms of documentation
    - Immunization record
    - Results of blood work indicating titers for chicken pox, measles, mumps and rubella.

Requirement 3:
Health Screening
Each volunteer must obtain medical clearance from a practitioner to work with children on in-patient units or to assist hospital staff in office settings or clinics and must have a health screening by a practitioner and be found free of communicable disease.

Children's National

Please print.

Volunteer Medical History Form

Name (Last, First, Middle):	Email Address:	DOB:
Address:		SSN:
Telephone (Home):	Telephone (Work):	Marital Status:
Department:	Position:	Employee ID #:
Do you have a primary care provider? ☐Yes ☐No		
Provider's Name:	Provider's Address:	Provider's Contact Number:
Present Disability, If any:		

Past Medical History

	Yes	No		Yes	No		Yes	No
Measles (Rubeola)	☐	☐	Back Trouble	☐	☐	Seizures	☐	☐
Measles (Rubella)	☐	☐	Eczema	☐	☐	Asthma	☐	☐
Mumps	☐	☐	Rheumatic Fever	☐	☐	Diabetes	☐	☐
Chickenpox	☐	☐	Pneumonia	☐	☐	Allergies	☐	☐
Whooping Cough	☐	☐	Kidney Disease	☐	☐	Hepatitis	☐	☐
Scarlet Fever	☐	☐	Venereal Disease	☐	☐	Herpes	☐	☐
Tuberculosis	☐	☐	Typhoid Fever	☐	☐	Hypertension	☐	☐
Arthritis	☐	☐	Anemia	☐	☐			
TB Assessment:			Sweats at night?	☐	☐	Chronic cough with mucus?	☐	☐
Unexplained fever for more than 1 week?	☐	☐	Unexplained weight loss?	☐	☐	Unexplained chest pain with breathing?	☐	☐

Operations? ☐ Yes ☐ No If "YES", please list type and year:

Have you ever been injured at work? ☐ Yes ☐ No If "YES", please give details:

Have you ever been or are you currently being treated for mental problems or nervousness? ☐ Yes ☐ No

Have you ever been a patient in a mental hospital? ☐ Yes ☐ No

Family History

		State of Health	Cause of Death
Father:	Living: ☐ Yes ☐ No		
Mother:	Living: ☐ Yes ☐ No		
Brother(s):	Living: ☐ Yes ☐ No		
Sister(s):	Living: ☐ Yes ☐ No		

Female Employees:
Last Menstrual Period Date: _____ ☐ Painful ☐Irregular ☐ Regular Pregnancies: _____ Children: _____

Immunization Dates (Year):
Tdap: _____ Varicella: _____ MMR: _____ Quantiferon/T-spot: _____ T.B Skin Test Date: _____ Result: ☐ Neg ☐ Pos

Do You Use:
Tobacco: ☐ Yes ☐ No Alcohol: ☐ Yes ☐ No

Are you taking any medications? ☐Yes ☐ No
List: _____

Tested for Color Blindness? ☐ Yes ☐ No

Are you Color Blind? ☐ Yes ☐ No

Emergency Contact

Name Relationship

Address City State Zip Phone

I CERTIFY THAT THE INFORMATION ABOVE IS ACCURATE TO THE BEST OF MY KNOWLEDGE. I ALSO UNDERSTAND THAT ANY DELIBERATE WITHHOLDING OF SIGNIFICANT HEALTH INFORMATION MAY RESULT IN MY DISMISSAL.

Signature Date

PLEASE NOTE THAT REQUIREMENT 3 MUST BE COMPLETED AND DATED THE SAME DATE OR AFTER THE SECOND PPD READING.

Volunteer Medical Form

To: Practitioner
From: Volunteer Services, Children's National Medical Center
RE: Volunteer Medical Requirements

_____has applied to be a volunteer at Children's National Health System. Hospital policy mandates that each volunteer meet specific health requirements. These requirements include all information listed in the below form and all information listed in the "Volunteer Medical History" form enclosed in this packet.

The volunteer shall provide evidence of health screening and proof of immunity by providing immunization records to vaccine-preventable diseases as required by Occupational Health at Children's National Health System.

Medical clearance must be validated by an outside practitioner. All documents must be translated into English. Please email all documents to **ohvolunteers@childrensnational.org**. Questions about our medical requirements may be referred to Occupational Health via email.

I hereby authorize the release of the medical information listed on the Volunteer Medical Form and the Volunteer Medical History form to Children's National Health System.

Volunteer Signature_____ Date _____

Parent Signature (for those under 18) _____Date_____

MANDATORY MEDICAL REQUIREMENTS

1. Tuberculosis Screening requirements

A. Each NEW volunteer must have TWO skin tests (PPD's). After each skin test is administered, the recipient must return within 48 to 72 hours to have the result read and recorded on this sheet. There must be at least seven days in between the placement of the first PPD and the placement of the second PPD. The second PPD must fall before the health screen in the same month.

B. Or you may show evidence of a recent (within 12 months of application) Quantiferon or T-Spot lab test.

C. PPD positive volunteer applicants must provide chest x-ray reading result (within 12 months of application).

**To ensure that the volunteer is free from Tuberculosis the volunteer must have a biennial health screen (completion of medical update form and placement/reading of Tuberculosis skin test (PPD)).

Please note the health screen MUST be completed after the 2nd PPD reading not before.

Have you had any known exposure to Tuberculosis? ☐ Yes ☐ No If "YES", Date:

****A positive test result <u>DOES NOT</u> indicate that you have Tuberculosis****

For office use only:

1st PPD Planted: Within the last 12 months Date: _____ Time: _____ 5TU Aplisol/ Tubersol Lot#: _____ Exp. Date: _____ RFA/LFA Signature: _____	**1st PPD Result:** Date: _____ Time: _____ Induration (MM): _____ Erythema Circle One: Negative Positive Signature: _____
2nd PPD Planted: Within 1 month of start date Date: _____ Time: _____ 5TU Aplisol /Tubersol Lot#: _____ Exp. Date: _____ RFA/LFA Signature: _____	**2nd PPD Result:** Date: _____ Time: _____ Induration (MM): _____ Erythema Circle One: Negative Positive Signature: _____

If the result of the TB skin test is positive, a chest x-ray is required and practitioner <u>must</u> fill in below. For newly positive skin test a Conversion form must be completed by practitioner. The conversion form will be given by Occupational Health.

Chest X-Ray: ☐ Yes ☐ No Date: Result: ☐ Positive ☐ Negative	
Comments: _____	
Practitioner Signature	Print Practitioner Name

2. Immunization Requirements

- Each volunteer must submit documentation of proof of immunity to chicken pox, Tdap, measles, mumps, and rubella, and current flu vaccine during the season. **This document should be separate from what is written in this medical packet.**

- The two acceptable forms of documentation are:
  - Immunization Records
  - Lab report indicating titers and reference ranges

MMR	The two (2) MMR vaccine series or one (1) MMR and one (1) Measles vaccine or laboratory report. NOTE: If born before 1957 you only need one (1) MMR vaccine.
Varicella	The two (2) vaccine series or titers to prove immunity
TDAP	The adult vaccine given by or after 2006
Flu vaccine	Documentation must be for recent/current flu season

If evidence of vaccinations cannot be provided for MMR or Varicella, the lab titer report must be on letterhead or a lab report with reference ranges associated on the report.

Please note that individuals born **during or after 1957** must provide proof of **TWO** measles vaccinations.
Date of mumps vaccination: _____ or Titer result: _____
Date of rubella vaccination: _____ or Titer result: _____
Date of measles (rubeola) vaccination: _____ or Titer result: _____

Children's National

Date of second measles vaccination for those born during or after 1957: _____
OR
Date of MMR1 _____ MMR2 _____

Date of 1st chicken pox vaccine: _____ or Titer result: _____

Date of 2nd chicken pox vaccine: _____

Date of TDAP vaccination:_____

Date of influenza vaccination: _____

3. Health Screening

Each volunteer must obtain medical clearance from a practitioner to work with children on in-patient units or to assist hospital staff in office settings or clinics and must have a health screening by a practitioner and be found free of communicable diseases.

For the practitioner: Does this individual have any physical, medical or mental disabilities or certain concerns which we should know about before making a volunteer assignment?
☐ YES ☐ NO If yes, please explain:

Does this individual have any communicable diseases?
☐ YES ☐ NO If yes, please explain:

Date of health screening ***MUST BE after READING OF 2nd TB TEST***

Sign-off for requirements (stamp and signature required):
Practitioner Signature: _____

Printed Name of Practitioner: _____

Address/City/State/Zip: _____

Office Telephone: _____ Date: _____

****Each volunteer MUST have his/her medical clearance renewed on a biennial basis.**

_____

Occupational Health Practitioner Signature: _____ Date_____

Clearance form completed and sent: ☐YES Date_____