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 3 of this packet.

- ☐ This completed checklist (page 1)
- ☐ Volunteer Initial Visit form (page 2)
- ☐ 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 complete packet with attached immunization records/titer results to ohvolunteers@childrensnational.org in one email once completed. Thank you!

Children's National
111 Michigan Avenue, NW
Washington, DC 20010
Email: ohvolunteers@childrensnational.org

Occupational Health
Volunteer Medical History

Please print.

Initial Visit

Please print.

Name (Last, First, Middle): | Email Address: | DOB:

Address:

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		Yes	No		Yes	No
Measles (Rubeola)	☐	☐	Back Trouble	☐	☐	Hypertension	☐	☐	Seizures	☐	☐	Herpes	☐	☐
Measles (Rubella)	☐	☐	Venereal Disease	☐	☐	Scarlet Fever	☐	☐	Asthma	☐	☐	Arthritis	☐	☐
Mumps	☐	☐	Rheumatic Fever	☐	☐	Typhoid Fever	☐	☐	Diabetes	☐	☐	Anemia	☐	☐
Chickenpox	☐	☐	Pneumonia	☐	☐	Tuberculosis	☐	☐	Allergies	☐	☐	Eczema	☐	☐
Whooping Cough	☐	☐	Kidney Disease	☐	☐	Hepatitis	☐	☐						

TB Risk Assessment

Do you have a history of the following?
☐ Latent TB Infection ☐ TB Treatment ☐ BCG Vaccine ☐ None

Please check all that apply:
☐ Temporary or permanent residence (for ≥ 1 month) in a country with a high TB rate *any country other than Australia, Canada, New Zealand, the United States, and those in western or northern Europe

☐ Current or planned immunosuppression *HIV, organ transplant, treatment with TNF-alpha antagonist, steroids (equivalent of prednisone ≥ 15mg/day for ≥ 1 month), or other immunosuppressive medication

☐ Close contact with someone who had infectious TB disease since the last TB test
☐ None

TB Symptom Screen

Please check all that apply:
☐ Cough lasting more than 2 weeks
☐ Coughing up blood
☐ Unintentional weight loss
☐ Night sweats
☐ Persistent fever (over 100 degrees)
☐ No Symptoms

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			State of Health
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: _____

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

Explanation of Medical Requirements and Procedures
Special Category Volunteers

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

The first medical form titled Initial Visit 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 three 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.
- All requirements must be completed by your outside practitioner.
- 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 be done before the health screen within 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).

Volunteers who continue their service for more than one year must complete the annual medical update form each year for Occupational Health clearance

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 must show 2 MMR vaccines, 2 Varicella vaccines, and a Tdap vaccine administered 2005 or later
  - Results of blood work indicating titers for varicella (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 diseases.

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

Special Category Volunteer Medical Form

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

_____has applied to be a special category volunteer at Children's National Medical Center. Hospital policy mandates that each volunteer meet specific health requirements. These requirements include all information listed in the form below and all information listed in the Initial Visit 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 Medical Center. **All requirements must be completed by your outside practitioner. Documents must be translated into English**. Questions about our medical requirements may be referred to a practitioner in Occupational Health via email**.** Please email all documents to **ohvolunteers@childrensnational.org**

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 Medical Center.

Special Category 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).

Volunteers who continue their service for more than one year must complete the annual medical update form each year for Occupational Health clearance

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:

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

Section to be completed by PPD administrator/reader:

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
     - Immunization record
     - Results of blood work indicating titers for chicken pox, measles, mumps and rubella.

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 **<u>during or after 1957</u>** must provide proof of **<u>TWO</u>** measles vaccinations.

Date of mumps vaccination: _____ or Titer result: _____

Date of rubella vaccination: _____ or Titer result: _____

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Date of measles (rubeola) vaccination:_____or Titer result:_____
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 an annual basis.**

Occupational Health Practitioner Signature: _____Date_____

Clearance form completed and sent ☐ YES Date_____