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, the Employee/Volunteer Medical History Form on page 2, 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 beginning on page 3, 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 at Children's National Health System.
- 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 7-8 am or 3-3:45pm.

***Requirement 1*:** Tuberculosis Screening requirements

1. Each NEW volunteer must have TWO skin tests (PPD's) WITHIN a three-week period, if one cannot be provided for the previous year. 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. If both skin tests are from the current calendar year, 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 within three weeks of the expected start date.

2. Or you may show evidence of a recent (within 12 months of application) Quantiferon or T-Spot lab test.
**To ensure that the volunteer is free from Tuberculosis the volunteer must have a biennial Tuberculosis skin test (PPD).

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

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 diseases.

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111 Michigan Avenue, NW
Washington, DC 20010
Email:ohvolunteers@childrensnational.org

Initial Visit

Please print.

Name (Last, First, Middle):	Email Address:	DOB:
Address:		SSN:
Telephone (Home):	Telephone (Work):	Marital Status:
Department:	Position:	Employee ID #:
Under care of physician? ☐Yes ☐No	If yes, for what?	
Physician's Name:	Physician's Address:	
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):
Diphtheria: _____ Tetanus: _____ Smallpox: _____ T.B Skin Test Date: _____ Result: ☐ Neg ☐ Pos Polio: _____ MMR: _____

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

Special Category Volunteer Medical Form

To: Practitioner
From: Volunteer Services, Children's National Health System
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 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. **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 Health System.

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) WITHIN a three-week period, if one cannot be provided for the previous year. 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. If both skin tests are from the current calendar year, 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 within three weeks of the expected start date.
   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).

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: _____

**To ensure that the volunteer is free from Tuberculosis the volunteer must have a biennial Tuberculosis skin test (PPD).

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

PPD Planted: (1) Date: _____ Time: _____ 5TU Aplisol/ Tubersol Lot#: _____ Exp. Date: _____ RFA/LFA Signature: _____	**PPD Result:: (1)** Date: _____ Time: _____ Induration (MM): _____ Erythema Circle One: Negative Positive Signature: _____
PPD Planted: (2)* Date: _____ Time: _____ 5TU Aplisol /Tubersol Lot#: _____ Exp. Date: _____ RFA/LFA Signature: _____	**PPD Result:: (2)*** 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 c**onversion 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.
- The two acceptable forms of documentation
  - Immunization record
  - Results of blood work indicating titers for chicken pox, measles, mumps and rubella.

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: _____
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 Please Explain:

Is this individual free from communicable disease?

☐ YES ☐ NO

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_____