# Orientation - Communicable Disease Review

Name:       Date of Birth:

Status:  Employee  Volunteer  Student  Physician

The Public Hospitals Act requires hospitals to maintain a record of immunization on all employees, physicians, volunteers, and students. Please ask your healthcare provider or Public Health Unit to record your immunization information below and bring the record to Occupational Health Coordinator. The information will be kept confidential.

**Immunizations:**

|  |  |  |
| --- | --- | --- |
| Vaccines Received | **Initial Series Date**  **(If known)** | Last Booster Date |
| Tetanus |  |  |
| Diphtheria |  |  |
| Polio |  |  |
| MMR (Measles, Mumps, Rubella) |  |  |
| Pertussis |  |  |
| Hepatitis B | 1. |  |
| 2. |  |
| 3. |  |
| Hepatitis B Titre | Date: | Result: |
| MMR Titre | Date: | Result: |
| Chicken Pox Titre | Date: | Result: |
| Influenza: Seasonal |  |  |
| Influenza: H1N1 |  |  |

**TB Skin Tests:** Date:       Result:

(2-step if done) Date:       Result:

Communicable Diseases:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Have you had the following:** | **Yes** | **No** | **At what age?** | **Documentation** | |
|  |  |  |  | **Yes** | **No** |
| Measles |  |  |  |  |  |
| Mumps |  |  |  |  |  |
| Rubella |  |  |  |  |  |
| Chicken Pox |  |  |  |  |  |

The above information is true and accurate to the best of my knowledge.

Signature: Date: