



Dear Volunteer:

There are legislated health requirements for working or volunteering in a hospital setting which are outlined on this form, and are in compliance with *The Ontario Hospitals Association & Ontario Medical Association Communicable Disease Surveillance Protocols*. If you are offered a volunteer position you will need to provide us with some information about your immunity. Some basic information is outlined below. If you don't have a family doctor, you can visit a Walk-In Clinic.

Note that TB tests are not covered by OHIP. We are unable to reimburse any fees that may be charged for this form. Health screening may take several weeks. **Volunteers should be aware that completion of health screening does not guarantee a volunteer placement therefore you should wait until requested by Volunteer Services to proceed with it.**

### **TUBERCULOSIS (TB)**

A TB skin test involves an injection into the skin of the forearm, with results being read 48 to 72 hours later. If the test is positive it is because you may have received BCG vaccine for Tuberculosis or you have been exposed to someone with Tuberculosis. Your doctor will further assess this with a Chest x-ray and discuss any symptoms.

If the first test is negative, a second test is performed in the other arm, one to four weeks later. This is followed by another reading in 48 to 72 hours. *The second test is taken as the final result.*

A documented previous 2-step test completed less than 2 years old is acceptable. If you have proof that you have had a 2-step TB skin test done greater than or equal to 2 years ago then you only require a 1-step TB Skin Test.

### **MEASLES, MUMPS, RUBELLA (German Measles) and VARICELLA (Chicken Pox)**

If your vaccinations have been documented and are up to date, you are considered immune, and nothing further has to be done. If your immunity status is unknown, your doctor will do some blood tests (the results take about a month) and follow up with you if necessary.

Please take the attached health surveillance sheet to your doctor to initiate appropriate testing. Your doctor can give you the **Volunteer Immunization Record as soon as the TB testing (or x-ray if required) is done, in order to begin volunteering as soon as possible.** Lab titres may still be pending. Please be sure to follow up with your doctor to complete additional immunization, if required. Return that final documentation to Volunteer Services as soon as possible, for our records.

We hope you enjoy your experience as a volunteer.



# Volunteer Immunization Requirements

**Volunteer Name:** \_\_\_\_\_

**Home Phone:** \_\_\_\_\_

**Email:** \_\_\_\_\_

**Dear Healthcare Provider:**

Your patient has applied to become a volunteer at Halton Healthcare. To comply with the Public Hospitals Act, we must know the immunity status for Mumps, Measles, Rubella (German measles) and Varicella (chicken pox) and vaccination for Tdap, of all persons carrying on activities in a hospital setting. Please complete this form, along with any follow up immunizations required, and provide it to your patient who is responsible to return it to us for medical clearance to start his/her volunteering.

### TUBERCULIN SKIN TESTING (Tb skin test)

**2 Step Tb Skintest** (baseline - the second step needs to be completed within 7-28 days of the first step)

Date of Step 1: \_\_\_\_\_ Result: (pos/neg) \_\_\_\_\_ Induration \_\_\_\_\_ mm

Date of Step 2: \_\_\_\_\_ Result: (pos/neg) \_\_\_\_\_ Induration \_\_\_\_\_ mm

**1 Step Tb Skintest** (for volunteers with record of previous negative 2 step Tb test ≥ 2 yrs ago – record must be included above or attached)

Date of Step 1: \_\_\_\_\_ Result: (pos/neg) \_\_\_\_\_ Induration \_\_\_\_\_ mm

**History of a Positive test:**

Chest x-ray (if required) Date: \_\_\_\_\_ Result: \_\_\_\_\_

Physician Statement Date: \_\_\_\_\_ Medically Cleared: \_\_\_\_\_

### MMR – Mumps, Measles and Rubella – ATTACH RECORDS

**MEASLES:** 2 MMR immunizations MMR #1 Date: \_\_\_\_\_ MMR #2 Date: \_\_\_\_\_

**OR** Laboratory Evidence of Immunity (Titre): Date: \_\_\_\_\_ Results (pos/neg): \_\_\_\_\_

**MUMPS:** 2 MMR immunizations MMR #1 Date: \_\_\_\_\_ MMR #2 Date: \_\_\_\_\_

**OR** Laboratory Evidence of Immunity (Titre): Date: \_\_\_\_\_ Results (pos/neg): \_\_\_\_\_

**RUBELLA:** 1 MMR immunization MMR #1 Date: \_\_\_\_\_

**OR** Laboratory Evidence of Immunity (Titre): Date: \_\_\_\_\_ Results (pos/neg): \_\_\_\_\_

### VARICELLA: one of the following is required – ATTACH RECORDS

• Laboratory Evidence of Immunity (Titre): Date: \_\_\_\_\_ Results (pos/neg): \_\_\_\_\_

• Varicella Vaccine (2 doses required): Vaccine #1 Date: \_\_\_\_\_ Vaccine #2 Date: \_\_\_\_\_

### TETANUS/DIPHTHERIA/PERTUSSIS

Date of last Tdap vaccination: \_\_\_\_\_

**Healthcare Provider Information (HCP):**

Date completed : \_\_\_\_\_

Name (print) of HCP: \_\_\_\_\_

Signature of HCP: \_\_\_\_\_



*Dr's Office Stamp*

**If you have any questions or concerns about the volunteer health review please contact:**

**GEORGETOWN:** (905) 873-0111 ext. 8153 [ghvolunteer@haltonhealthcare.com](mailto:ghvolunteer@haltonhealthcare.com)

**MILTON:** (905) 878-2383 ext. 7740 [mdhvolunteer@haltonhealthcare.com](mailto:mdhvolunteer@haltonhealthcare.com)

**OAKVILLE:** (905) 338-4643 #1 [volunteer@haltonhealthcare.com](mailto:volunteer@haltonhealthcare.com)