Royal Victoria Regional Health Centre

FORM F

Occupational Health and Safety

IMMUNIZATION RECORD/RESPIRATORY FIT FORM

Physician/Residents/Observers

ID#_____

Last Name	First Name

Date of Birth

DD/MM/YYYY

TUBERCULOSIS (TB) STATUS

Tuberculin testing: 2-step required. 2nd step must be given 1-4 weeks after 1st test in opposite arm if 1st test is less than 10mm induration.

1st Step:	Date planted:	Date read:	Induration (mm)
2nd Step	Date planted:	Date read:	Induration (mm)

If a 2-step has previously been established but is more than 4 weeks prior to your start date, one additional TB test is required (1-step TB). A 2-step must be documented above. If a 1-step have been done in the last 12 months a 1-step is required. If two or more 1-step TB tests have been done > 12 months ago, a 1 step is required

1-step:	Date planted:	Date read:	Induration(mm)

Chest x-ray: Required if TB skin test is 10mm induration or greater or if previously TB positive a Chest X-ray must have been done within the last 12 months. Positive skin test must be documented above.

X-ray:	Date:	Result:

LAB CONFIRMED IMMUNITY/IMMUNIZATION STATUS

Measles	Laboratory evidence of immunity (titres)	Measles-Date of lab test:	Result: ☐ Immune ☐ Not Immune
	OR 2 MMR vaccines	Date of 1st MMR:	Date of 2nd MMR
Mumps	Laboratory evidence of immunity (titres)	Mumps-Date of lab test:	Result: ☐ Immune ☐ Not Immune
	OR 2 MMR vaccines	Date of 1st MMR:	Date of 2nd MMR
Rubella	Laboratory evidence of immunity (titres)	Rubella-Date of lab test:	Result:
	OR 2 MMR vaccines	Date of 1ST MMR:	Date of 2nd MMR:

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Varicella	Laboratory evidence of immunity (titres)	Varicella: Date of lab test:	Result: ☐ Immune ☐ Not Immune
	OR History of disease (chicken pox or shingles)	History? ☐ Yes ☐ No	Year (if known):
	OR Varicella vaccine (2 doses required)	Date of 1st dose:	Date of 2nd dose:
Hepatitis B	Laboratory evidence of immunity (antibody titre must be provided if vaccinated)	Date of lab test:	Result: ☐ Immune ☐ Not Immune
	Vaccination is highly recommended for employee who may have exposure to human blood and body fluids	Received vaccine? ☐ Yes ☐ No	Dates if known: Hep #1 _____ Hep #2 _____ Hep #3 _____

Tetanus/Diptheria/Pertussis	Not mandatory but Tdap is recommended for healthcare workers	(please check one) ☐ Td Date: _____ ☐ Tdap (Adacel) Date: _____
Influenza	Not mandatory but highly recommended	Date of last vaccine:

N95 Respirator Fit test: Please check one (This is a mandatory requirement done every 2 years)

- ☐ 3M 1860 reg Date: _____
- ☐ 3M 1860 small Date: _____
- ☐ 3M 9210/1870 Date: _____
- ☐ 3M 8110 small Date: _____
- ☐ 3M 8210 Date: _____

Relatives are not permitted to complete and sign this document. Please retain a copy for your records.

Completed by: Physician/OHN/RN _____ Signature/Stamp _____ Date _____
Print name

I _____ agree to release the above information to Occupational Health and Safety at Royal Victoria
(Physician name)

Regional Health Centre.

Physician/Resident Signature _____ Date _____

The personal information contained on this form is collected in accordance with the Health Protection and Promotion Act, R.S.O. 1990, Chapter H.7 for the purposes of collecting your immunization information in compliance with the S.I.S. Policy. Questions about this collection can be directed to: Manager, Occupational Health 44550

Revised January 2013