New Volunteer Health: Mandatory Requirements

Community and Volunteer Resources

Oak Valley Health requires all new volunteers to provide current immunization records that meet our organizational policy and the minimum standards for all Ontario hospitals (OHA/OMA Guidelines). The purpose of these requirements are to limit the risk of exposure and transmission of communicable diseases for staff, patients, and volunteers, and support a healthy and safe work environment.

As it may take 4-6 weeks for completion, the requirements should be started in advance of your start date. **In order to fulfill the terms and conditions of your offer, all the mandatory immunization requirements must be provided to Community and Volunteer Resources within four weeks of your start date.**

- **Form A:** Must be fully completed and signed by the volunteer.
- **Form B:** Can be filled out by a Primary Care Provider or Occupational Health Nurse at a previous employer

<u>To obtain your immunization and health records</u>:

- Where applicable, contact your ***current or past*** employer, or organization where you performed volunteer work, and request a copy of your record from the Occupational Health Department.
- Contact your school (college/university) and request a copy of your immunization record from Student Health Services.
- Contact the Public Health Department in the school district you attended to ask for a copy of your vaccination record.
- Obtain your childhood record (often a yellow card or form) from your family doctor or parents. Other health care professionals you have received care from may also have pertinent documentation of immunity such as obstetricians, midwives or family physicians.
- Blood tests are required if you are unable to confirm vaccination dates. Please be advised test results may take 2-4 weeks. NOTE: The hospital does not provide blood work requisition for this and it will have to be arranged with your *Primary Care Provider*

The medical information collected will be maintained in confidence and will remain part of your volunteer records.

Oak Valley Health

FORM A: HEALTH HISTORY

To be completed by *volunteer*

Name: _____ **Date of Birth:** _____

(Last name, First name) (DD/MM/YYYY)

Have you ever received medical treatment for the following:

Yes	No		Yes	No	
☐	☐	Back/neck injury or pain	☐	☐	Hepatitis/HIV
☐	☐	Upper limb (shoulder, elbow, wrist, hand) injury or pain	☐	☐	Respiratory problems
☐	☐	Lower limb (hip, knee, lower leg, ankle, foot) injury or pain	☐	☐	Immunosuppression
☐	☐	Visual problems	☐	☐	MRSA/VRE
☐	☐	Hearing problems	☐	☐	Skin conditions of the hand
☐	☐	Seizures/Loss of consciousness			

If checked yes, please explain:

_____

_____

List any allergies or sensitivities (e.g. Latex, rubber, food, medications, environmental):

_____

Describe the type of reaction you have experienced and any medical follow-up/treatment to noted allergies:

_____

_____

Do you have any permanent restrictions or functional limitations? If so, please describe:

_____

Do you have any disability for which you require accommodation under the Human Rights code? If so, please describe:

_____

Do you have restrictions that require accommodation related to your personal safety in the event of an emergency? □Yes □ No

_____

I hereby declare that this information as well as the information I provided prior to being hired is true and complete. I understand that all medical information provided by me will be kept confidential as per the Oak Valley Health Confidentiality Policy. Should I have any need for accommodation due to an existing disability, the Oak Valley Health accommodation policy and disability management procedures will be followed and an accommodation will be provided if possible.

Volunteer signature: _____ **Date:** _____

Oak Valley Health

FORM B: IMMUNIZATION STATUS RECORD

To be completed by a medical practitioner OR by employee with supportive documentation

LAST NAME:	FIRST NAME:	DOB (DD/MM/YYYY):
PREFERRED PHONE:	EMAIL:	
JOB TITLE:	DEPARTMENT:	
START DATE:	SUPERVISOR:	

TUBERCULOSIS SCREENING (2-Step Required):

If 1st test is NEGATIVE: 2nd step must be given 7 to 21 days after 1st test in opposite arm.			
1st step:	Date planted:	Date read:	Result (+ or -) and (mm):
2nd step:	Date planted:	Date read:	Result (+ or -) and (mm):
History of a BCG Vaccine: ☐ Yes ☐ No		If answered yes, date BCG administered (DD/MM/YYY):	
If the above NEGATIVE 2-Step TB test was NOT completed within the last 12 months, a 1-Step TB test must ALSO be completed.			
1st step:	Date planted:	Date read:	Result (+ or -) and (mm):
If either test is POSITIVE (i.e. > 10mm induration), a chest x-ray is required dated after the date of the positive TB test. Documentation of positive test is also required.			
X-ray:	Date:	Result (include report):	

PROOF OF IMMUNITY (Required):

Measles:	Laboratory evidence of immunity (titres) †	Date of test:	Result: ☐ Immune ☐ Not Immune
Mumps:	Laboratory evidence of immunity (titres) †	Date of test:	Result: ☐ Immune ☐ Not Immune
Rubella:	Laboratory evidence of immunity (titres) †	Date of test:	Result: ☐ Immune ☐ Not Immune
OR documented evidence of 2 MMR vaccines at least 4 weeks apart.		**Date of MMR #1:**	**Date of MMR #2:**
Varicella:	Laboratory evidence of immunity (titres), † **OR**	Date of test:	Result: ☐ Immune ☐ Not Immune
	Varicella vaccine (2 doses required)	**Date of 1st dose:**	**Date of 2nd dose:**
Tetanus/ Diphtheria/ Pertussis:	One adult dose of TDAP is mandatory. TD is *recommended* every 10 years thereafter. ☐ Tdap Date: _____ ☐ Td Date: _____		
Hepatitis B:	Date of lab test:	Titre Level:	Result: ☐ Immune ☐ Not Immune
	Series #1 Vaccination Dates	Vaccine #1:	Vaccine #2: / Vaccine #3:
	Series #2 Vaccination Dates	Vaccine #1:	Vaccine #2: / Vaccine #3:

IMMUNIZATION STATUS (Recommended):

Influenza:	**Date of most recent vaccine:** _____

Information collected on this form will be maintained in confidence.

_____ _____

Health Practitioner Signature Date

_____ _____

Volunteer Signature Date

(OFFICE STAMP HERE)