

TB Test Form

VOLUNTEER HEALTH CLEARANCE

Name: _____ Home Phone _____
Last First MI

Address: _____

City/State/Zip: _____

Date of Birth: _____ SS # _____

IMMUNIZATION REQUIREMENTS

Documentation of the following will be required of all volunteers prior to beginning their affiliation at Georgetown University Hospital:

- Proof of immunity to Measles, Mumps and German Measles by providing documentation of two (2) MMR vaccines; or two (2) measles, one (1) rubella and one (1) mumps; or laboratory evidence of immunity. (Persons born before 1957 require documentation of one (1) MMR).
- Evidence of chickenpox (varicella) disease, laboratory evidence of immunity, or documentation of immunization with two (2) doses of chickenpox vaccine.
- Tuberculosis screening by Mantoux PPD testing performed within twelve (12) months prior to start date.
- If history of positive PPD, must provide documentation of the positive PPD, and a negative chest Xray done within 12 months prior to start date.
(Volunteers with a history of BCG vaccination are still required to have a PPD unless documentation of a positive PPD is provided.)

(Employee Health will provide the necessary PPD's if needed. If your PPD is positive you will be referred to your primary care provider for a Chest Xray. Results must be presented to Employee Health prior to volunteering.)

Health History

Allergies: _____

Please answer the following questions to the best of your ability:

Have you had any of the following communicable diseases? (check appropriate box) ___ Chickenpox
___ Measles ___ German Measles ___ Mumps ___ Hepatitis B ___ Hepatitis C

Tuberculosis History: Date of last TB skin test _____ Result _____ Have you ever had a positive skin test for tuberculosis? ___ Yes ___ No If yes, when: _____ If yes, did you take the medication INH? ___ Yes ___ No. If yes, for how many months? _____
Have you ever had a vaccine called BCG? ___ Yes ___ No

Please list any medications that you currently take: _____

Signature of EHS Health Care Practitioner _____

Date _____

Date	Annual Surveillance (PPD/CXR/Questionnaire)	Date PPD read and result, or CXR result	Signature

(if needed)

PPD # 2 Date planted _____
 Date Read _____
 Result in mm _____

PPD # 1 Date planted _____
 Date Read _____
 Result in mm _____

Documented positive PPD attached _____ Documented CXR within 12 months attached _____
 Documented negative PPD within 12 months attached _____

TUBERCULOSIS SCREENING

DISEASE	IMMUNIZATION	SEROLOGY
Measles		
Rubella		
Mumps		
Chickenpox		
Hepatitis B Vaccine		

Do not write below this line - for Employee Health Service use only:

Please list any health problems for which you have been, or are currently being treated for _____