

Volunteer Immunization Record Submission

In compliance with the requirements set out in the *Public Hospital Act* Regulation 965 by-law 4(1)d.

Please provide your completed document to Occupational Health, Safety & Wellness: ohs@wchospital.ca or fax to 416-323-6164.

First Name:		Date of Birth:	
Last Name:			
*TUBERCULOSIS SCREENING	2-STEP TUBERCULIN SKIN TEST (TST)		
	Date planted:	Date read:	Induration (mm):
	Date planted:	Date read:	Induration (mm):
Chest X-Ray (if skin test positive) Date: <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal Comments:			
*MEASLES	Lab evidence of immunity (serum measles IgG)	Date of test:	<input type="checkbox"/> Immune <input type="checkbox"/> Not immune
	OR documentation of 2 doses of live measles vaccine (e.g. MMR) on or after 1 st birthday	Date of 1 st MMR:	Date of 2 nd MMR:
*RUBELLA	OR Lab evidence of immunity (serum rubella IgG)	Date of test:	<input type="checkbox"/> Immune <input type="checkbox"/> Not immune
	OR documentation of immunization with live rubella vaccine (e.g MMR) on or after 1 st birthday	Date of MMR:	
*MUMPS	Lab evidence of immunity (serum mumps IgG)	Date of test:	<input type="checkbox"/> Immune <input type="checkbox"/> Not immune
	OR documentation of 2 doses of mumps vaccine (or trivalent measles-mumps-rubella (MMR) vaccine) on or after 1 st birthday	Date of 1 st MMR:	Date of 2 nd MMR:
*VARICELLA (CHICKENPOX)	Lab evidence of immunity (serum VZV IgG) (previous diagnosis or history is not accepted)	Date of test:	<input type="checkbox"/> Immune <input type="checkbox"/> Not immune
	OR Varicella vaccine (2 doses required)	Date of 1 st dose:	Date of 2 nd dose:
*COVID-19	Documentation of 2 doses of COVID-19 vaccine	<input type="checkbox"/> Pfizer	Date of 1 st dose:
		<input type="checkbox"/> Moderna <input type="checkbox"/> AstraZeneca <input type="checkbox"/> Other: _____	Date of 2 nd dose:

***Mandatory Immunizations**

Completed by: _____
Physician/RN _____ Signature _____ Date _____

I consent to release the above information to the Occupational Health, Safety and Wellness Department, Women's College. I understand that no personal health information will be released by OHSW without my express consent. *Only my status regarding compliance or non-compliance with communicable disease protocols will be provided to the Department of Medical Affairs/Management/Human Resources.*

Volunteer's Signature _____ Date: _____