**Volunteer Services & Student Relations**
**484-526-4600(P) | 484-526-4199 (F)**
**volunteers@sluhn.org**

# IMMUNIZATION HISTORY CERTIFICATION

| | | |
|---|---|---|
| **Name:** | | **Today's Date:** |
| **Date of Birth:** | **Department:** | *VOLUNTEER SERVICES* |
| | **Work Location:** | |
| **Position, please check one:** ☐ **Volunteer** | | |

St. Luke's University Health Network follows CDC and Immunization Coalition Healthcare Personnel Vaccination Recommendations. Please complete the form in its entirety. This form must be signed by a Healthcare Professional on page 2. Immunizations and lab tests must be completed BEFORE beginning your experience. Once all data is collected and reviewed, the certification form will be completed.
If non-immune, the 1st dose of a multi-dose series must be administered prior to/or on start date. The volunteer is expected to ensure subsequent doses are received and are required to provide to Volunteer Services. Volunteer Services will follow up on outstanding clearances.

## REQUIRED IMMUNIZATIONS

**Two documented doses of MMR vaccine or MMR titers (IgG) showing immunity to each of the 3 diseases – proof must be provided**
*Live virus vaccines (MMR) affect accuracy of Tuberculin Skin Test (TST/PPD); please complete at least one TST dose at the same time or prior to receiving the MMR vaccine.

| | | | | |
|---|---|---|---|---|
| **MEASLES** | _____ Dose 1 | _____ Dose 2 | **OR** | _____ Date & result of Measles Titer (provide copy of positive/immune IgG) |
| **MUMPS** | _____ Dose 1 | _____ Dose 2 | **OR** | _____ Date & result of Mumps Titer (provide copy of positive/immune IgG) |
| **RUBELLA** | _____ Dose 1 | | **OR** | _____ Date & result of Rubella Titer (provide copy of positive/immune IgG) |

**VZV: Two documented doses of Chickenpox vaccine or Varicella titer (IgG) showing immunity – proof must be provided**
**Live virus vaccines (Varicella) affect accuracy of Tuberculin Skin Test (TST/PPD); please complete at least one TST dose at the same time or prior to receiving the Varicella vaccine.*

**History of Chickenpox** **Having disease does NOT meet this requirement; please continue below…*

| | | | | |
|---|---|---|---|---|
| Chickenpox (Varicella) | _____ Dose 1 | _____ Dose 2 | OR | _____ Date & result of Varicella Titer (provide copy of positive/immune IgG) |

**Up-to-date TDAP (Tetanus-Diphtheria-Pertussis) is required**
**If last Tdap is ≥10 years and/or was a Td only; administer a **Tdap** vaccine now*

Most recent **TDAP** administration DATE:_____

(Page 2) **NAME:**

**Baseline Tuberculosis (TB) Testing:** One of the following is required **on/or within 3 months** of start date: (1) 2-step Tuberculin (TB) Skin Test (TST) or Mantoux (PPD); (2) 1-step if TST is performed annually; or (3) TB blood test (IGRA) QuantiFERON-TB Gold or T-SPOT
Document dates & results below **– proof must be provided / TBQ-Hx-Risk form is required**
**TB Questionnaire: Please complete and submit as part of the health history clearance**
Employee Health: TB Questionnaire received/reviewed ☐

_____/_____ _____/_____ _____/_____

**TST** Date/Result Date/Result **or** **IGRA** Date/Result

**PPD** **Test #1** **Test #2** ***Circle blood test: QFT T-SPOT**

**Live virus vaccines (MMR/Varicella) affect accuracy of TB Skin Test; please complete at least one TST at the same time or prior to receiving MMR-V immunizations.*

***Past positive TST/PPD/IGRA:** Provide copy of positive TB test, CXR results, documentation if treated. Repeat CXR if over 1 year. *BCG administration without TB testing is not acceptable.* ***New positive**: Do not repeat QFT, order CXR, refer to provider for follow up. Needs clear CXR prior to start date.

**Influenza (Flu shot):** Mandatory/annual influenza vaccination for anyone in the Network between **Oct 1 to March 31** *or longer depending on influenza activity* - **proof of current flu vaccine must be provided or a medical exemption submitted & approved**

Most recent **flu shot** administration DATE: _____

**COVID19 Vaccination:** Include which vaccine, dates administered – **proof must be provided or a medical or attestation exemption submitted & approved.**

**DATES: _____ _____ _____ Official Brand Type _____ (i.e. COVID 19 2023-2024)**

**OPTIONAL IMMUNIZATIONS**

**Hepatitis B Vaccine Series:** Documentation of 3 vaccine doses or titer showing immunity – **proof must be provided**. HBV immunity is strongly encouraged for those with risk of exposure to BBF. *Declination requires signature*.

**Hepatitis B Vaccine Series:** _____ _____ _____
Dose 1 Dose 2 Dose 3

_____/_____
**HBsAb:** Date/result (provide copy)

**Declination** of Hepatitis B vaccine at this time: _____ _____
Signature Date

**CLEARANCE: Must be completed and signed by a licensed Healthcare Professional**
**Family members are not permitted to complete/sign**

*I certify that the information contained in this document is true, accurate, and complete according to the medical records available to me.*

_____ _____ _____
Signature of Health Care Professional Printed Name Date

Title of HC professional: Name of Practice:

**Review and clearance completed by SLUHN Network Employee Health Services:**

Immunizations/Titers up-to-date: YES, Cleared NO, Need:

Reviewed by: Title: Date:

**Follow up (when indicated) by SLUHN Network Employee Health Services:**

F/U review completed by: Title: Date:

Records complete upon final review: YES NO Need: