PREPLACEMENT IMMUNIZATION STATUS FOR THE ED PEER PROGRAM

Upon acceptance to the PEER Program you must provide the following information in order to begin orientation. The information needed includes:

- Tuberculosis Screening
- Immunization status including MMR, Chicken Pox, and Hepatitis B
- Evaluation of Latex Allergy or Sensitivity
- Acknowledgement that HCMC is a scent free working environment
- Emergency Contact information in case of an emergency
- Date Completed: ________________

<table>
<tr><td colspan="2">Last Name:</td><td>First Name:</td><td>Middle Initial :</td></tr>
<tr><td colspan="2">Maiden/Other name:</td><td>Social Security
Number: xxx-xx-_____</td><td></td></tr>
<tr><td colspan="4">Street Address:___________________________________

City:__________________________ State: ____________ Zip:_____ Phone (   )_________</td></tr>
<tr><td>Sex: ☐ Male ☐ Female</td><td colspan="2">Date of Birth:</td><td>Place of Birth:</td></tr>
<tr><td colspan="4">Places where you have lived or traveled outside USA:</td></tr>
<tr><td colspan="4">In Emergency Notify:____________________________________ Phone (   )</td></tr>
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Immunity Profile

Please **provide documented** history of the following immunizations or titers, and Tuberculosis screening information. Indicate which types of records have been attached. If no history, the following page can be used at your clinic or pharmacy to be screened.

Covid-19:

- ❒ Provide documentation of 2 doses of Pfizer or Moderna
  OR
- ❒ Provide documentation of 1 dose of Janssen vaccine

Tuberculosis Screening:

- ❒ I have provided documentation of one Tuberculosis lab test (T-Spot or Quantiferon Gold) within 3 months
  OR
- ❒ I have provided documentation of two TB Skin Tests within the last year. One of the skin tests MUST be within the **last 3 months**.

If history of a positive TB skin or blood test:

- ❒ 1. Provide documentation of dates when TB test was positive (either skin test or blood test).
- ❒ 2. Provide documentation of chest x-ray within the last 6 months.
- ❒ 3. *If applicable*, provide documentation of drug therapy (INH, etc.) and duration of treatment. **Chest x-ray also completed within the last 6 months.**
- ❒ 4. Please check any symptoms, lasting longer than two weeks, that you are having or have had in the last year.
  - Change in cough ❒ Yes ❒ No
  - Night sweats ❒ Yes ❒ No
  - Weight loss ❒ Yes ❒ No
  - Loss of appetite ❒ Yes ❒ No
  - Fatigue ❒ Yes ❒ No
  - Fever ❒ Yes ❒ No
  - Bloody sputum after coughing ❒ Yes ❒ No

Measles, Mumps, and Rubella:

- ❒ I have provided documentation of 2 MMR vaccines on or after first birthday
  OR
- ❒ I have provided documentation of positive titer showing immunity

Chicken Pox (Varicella):

- ❒ I have provided documentation of 2 Varicella vaccines
  OR
- ❒ I have provided documentation of positive titer showing immunity

Hepatitis B:

- ❒ I have provided documentation of 3 Hepatitis B vaccines
  AND
- ❒ I have provided documentation of positive titer showing immunity

Routine Two-Step TB Test

Can be done by primary MD, community clinic, school health service or Walgreens.
Bring this form with you to your health care provider.

Applicant's Name: ____

STEP ONE	STEP TWO
Tuberculin Skin Test: (PPD 5 T.U. Intradermal) Date given: _______________________________________ ☐ Aplisol (JHP) ☐ Sanofi ☐ Other_______________ Lot #: _______________________________________ Site: ☐ Right Forearm ☐ Left Forearm ☐ Other _______________________________________ Given by: ____________________________________ **May be read on:** ____________________________________ *** **MUST BE READ 48-72 HOURS AFTER ADMINISTRATION** **TST Results:** Date Read: ____________________________________ Reading: __________________________ **mm induration *****IF THERE IS ANY INDURATION OR REDNESS, THE READING MUST BE DONE IN EOHW.*** Name (please print) and signature of reader: ____ Facility/Location:_____________________________	Tuberculin Skin Test: (PPD 5 T.U. Intradermal) Date given: _______________________________________ ☐ Aplisol (JHP) ☐ Sanofi ☐ Other_______________ Lot #: _______________________________________ Site: ☐ Right Forearm ☐ Left Forearm ☐ Other _______________________________________ Given by: ____________________________________ **May be read on:** ____________________________________ *** **MUST BE READ 48-72 HOURS AFTER ADMINISTRATION** **TST Results:** Date Read: ____________________________________ Reading: __________________________ **mm induration *****IF THERE IS ANY INDURATION OR REDNESS, THE READING MUST BE DONE IN EOHW.*** Name (please print) and signature of reader: ____ Facility/Location:_____________________________

LATEX SENSITIVITY SCREENING

Name: ____ Date: ___________

PLEASE ANSWER THE FOLLOWING QUESTIONS:	YES	NO
Have you ever had eczema, rashes or itching on hands after wearing gloves?		
Have you developed hives after wearing gloves or being exposed to latex?		
Have you ever developed shortness of breath or wheezing after wearing gloves or being exposed to latex?		
Have you ever had throat swelling or an anaphylactic reaction related to latex?		
Do your lips swell up or itch after blowing up a balloon?		
Have you ever reacted to condoms or diaphragms? (swelling, pain, itching or hives)		
Do you have reactions (swelling, itching, trouble breathing or swallowing or hives) during dental procedures?		
Are you allergic to any fruits or vegetables (banana, avocado, tropical fruits, kiwi, chestnuts, tomatoes, potatoes & celery)?		
Do you have a history of asthma?		

****If you answered "yes" to any of the questions above, please complete the questions below****

IRRITANT CONTACT DERMATITIS ASSESSMENT (skin only)	YES	NO
Do you have rashes, itching, cracking, scaling or weeping of the skin from exposure to latex?		
Have the above symptoms changed or worsened in the past year?		
Have you tried a non-latex alternative?		
If so, have you had the same or similar symptoms as with the latex product?		
Do these symptoms persist when you stop all exposure to latex?		

ALLERGIC CONTACT URTICARIA (HIVES) ASSESSMENT (skin only)	YES	NO
When you have contact with latex or are exposed to others wearing latex, do you get hives, red itchy or swollen skin, or water blisters?		

IMMUNE SYSTEM RESPONSE ASSESSMENT ** MD note needed**	YES	NO
When you have contact with latex, powdered latex gloves or are exposed to others wearing latex, have you noticed any: Itchy red eyes, fits of sneezing, runny nose or itching of the nose or mouth?		
Shortness of breath, wheezing, chest tightness or difficulty breathing?		
Other acute reactions including generalized or severe swelling or shock?		