Regions Hospital
HealthPartners
Employee Health & Wellness
Ph: 651-254-3301 FAX: 651-254-2446
E-mail: regionsemployeehealthwellness@healthpartners.com

Please Print:

Applicant Name: _____

Birthdate: _____ Phone Number: _____

Email: _____

Volunteer Services - Initial Screening Tuberculosis and Immunization History

INSTRUCTIONS: COMPLETE THE VOLUNTEER SECTIONS OF FORM *(FRONT AND BACK)* BEFORE YOUR SCREENING.

I authorize Regions Hospital Employee Health to access my EPIC record or create one on my behalf to order and obtain lab test results. I authorize Regions Hospital Employee Health to access my Minnesota Immunization Information Connection (MIIC) record and/or the Wisconsin Immunization Registry (WIR) record for the sole purpose of completing this health screening. I may revoke this authorization at any time by notifying Employee Health, Regions Hospital, 640 Jackson Street Mailstop 11501H, Saint Paul, MN 55101, in writing.

_____ _____ _____

(Print Applicant Name) **(Applicant Signature)** **(Date)**

Important: Provide copies of all your immunization records; vaccination dates, and blood test results showing immune status.

Tuberculosis (TB) Screening (Required prior to volunteering and to be done at Regions Hospital during the onboarding process.)

VOLUNTEER SECTION - Answer all questions in this box:

1. Check any symptoms you currently have and have had for more than three weeks: ☐Persistent cough ☐Excessive Fatigue ☐Hoarseness ☐Coughing up blood ☐Excessive weight loss ☐Excessive sweating at night ☐Persistent fever ☐No Symptoms
2. Were you born outside of the U.S.A.? ☐No ☐Yes: Country of birth _____ Year you moved to the U.S.A. _____
3. Have you traveled or lived outside of the U.S.A.? ☐No ☐Yes: Where and for how long? _____
   _____
4. Have you ever been exposed to or lived with a person diagnosed with and/or treated for TB? ☐No ☐Yes: When _____
5. Do you work or volunteer in a group home, prison, or homeless shelter? ☐No ☐Yes: Where _____
6. Has a health provider told you that your immune system is not working or cannot fight infection? ☐No ☐Yes ☐Unknown
7. Have you ever received the BCG Vaccine? ?☐No ☐Yes ☐Unknown
8. Have you ever had a TB skin test (also known as Mantoux, PPD, or TST)?
   ☐No ☐Unknown ☐Yes: Date of last test _____ Result _____
9. Have you ever had a TB Blood Test (such as Quantiferon Gold or Q-Gold)?
   ☐No ☐Unknown ☐Yes: Date of last test _____ Result _____
10. Have you ever had a chest x-ray for TB?
    ☐No ☐Yes: Date _____ Result (bring copy) ☐Normal ☐Positive for TB ☐Other
11. Have you ever been treated for TB or Latent TB?
    ☐No ☐Unknown ☐Yes: Medication ☐Isoniazid (INH) ☐Other_____
    Year treatment started: _____ How many months did you take the medication?_____ When was your last dose?_____

Sections Below To Be Completed by Employee Health and Wellness Nurse

Is volunteer a Minor? ☐No ☐Yes - verify parent or guardian is present and initial here: _____
Has volunteer had the following within the last 6 weeks? Live virus vaccine ☐No ☐Yes Severe viral illness? ☐No ☐Yes
Is TB Blood test contraindicated? ☐No-order Lab ☐Yes – consult with program coordinator/lead RN
☐**TB Blood Test Ordered** Date: _____Result: _____ Result Date:_____
☐**Additional evaluation required: Chest X-ray Ordered** Date: _____Result: _____
☐**Reviewed by EHW RN** & **Referred to PCP** with form & copy of records: Referral Date: _____

Tetanus, Diphtheria, Pertussis (Tdap)	☐Meets Requirement	☐Vaccinated	
Influenza (October 1-March 31)	☐Meets Requirement	☐Vaccinated	
Chicken Pox (Varicella)	☐Meets Requirement	☐Vaccinated	☐Titer Drawn
Red Measles (Rubeola) (MMR)	☐ Meets Requirement	☐Vaccinated	☐Titer Drawn
Mumps (MMR)	☐ Meets Requirement	☐Vaccinated	☐Titer Drawn
German Measles (Rubella) (MMR)	☐ Meets Requirement	☐Vaccinated	☐Titer Drawn

This volunteer has completed the required TB and immunization screening in Employee Health and Wellness and is cleared to begin volunteering. **RN Signature** _____ **Date** _____

☐Documented final clearance in Midas ☐Final clearance emailed to Volunteer Services **RN Initials:**_____ **Date:**_____

Regions Hospital®
HealthPartners®

THIS SECTION TO BE COMPLETED BY MINOR APPLICANTS ONLY

Minor Consent for:_____ Date of Birth_____
(First and Last Name of applicant)

I hereby declare that I am the parent or legal guardian of the above-named child. I understand that to be eligible to volunteer at Regions Hospital, my child must complete immunization and tuberculosis (TB) screening through Regions Hospital Employee Health and Wellness. I hereby authorize Regions Hospital Employee Health and Wellness to:

- Review immunization records sent with my child or access my child's immunization records through the Minnesota Immunization Information Connection (MIIC) and/or the Wisconsin Immunization Registry (WIR)
- Access my child's EPIC record or create one on their behalf to order and obtain lab test results.
- Administer and review results from the required TB blood test.

Please check the correct statement below:

- ____ My child has **never** had a TB skin test (mantoux) or TB blood test.
- ____My child had a previous TB skin test (mantoux) or TB blood test that was **negative.**
- ____My child had a previous TB skin test (mantoux) or TB blood test that was **positive.**

If your child has a history of a positive TB skin test, do not sign this form. Please call our office (254-3301) to discuss other options.

I understand that I have the option to be present for this screening.

I understand that if immunization history is incomplete or the result from the TB blood test is positive for Tuberculosis, I will be contacted by Employee Health and Wellness. I also understand that this may delay the start date of volunteering.

If Employee Health and Wellness has questions during this pre-volunteer screening, I may be reached at the following number(s) (please indicate order of preference):

Home phone: _____
Office phone: _____
Cell phone: _____

I have read and considered this consent before signing it.

_____ _____
(Signature of Parent or Legal Guardian) **(Date)**

_____ _____
(Print Name) **(Relationship to Minor)**

If you have any questions or concerns, please contact Employee Health and Wellness 651-254-3301.