History and Immunization Record

Please complete and bring this form with you to your scheduled Employee Health visit.

NAME: _____ _____ _____
LAST FIRST MIDDLE

DATE of BIRTH: _____
MM/DD/YYYY

Part I: Completed by all VCU Health System Team Members

A. **FLU SHOT –** Required for all VCUHS team members. Please attach documentation and date of last flu shot.

The information in Part II is REQUIRED for clinical providers and/or team members with DIRECT patient care. If you are not in a direct patient care position, meaning you have no patient contact (ie: Administration, Billing, IT, Finance, etc.) you do not need to complete Part II of this form.

PART II: Clinical providers with direct patient care. Information is to be completed and signed by a Health Care Provider. Dates must include month, day and year.

B. TUBERCULOSIS – Check appropriate box:

Please provide documentation of TB assessment completed by one of the following methods:

[ ] **Mantoux TB skin test: You must provide documentation of two TB skin tests (TST) a TST within the last year and a current TST complete no more than 30 days prior to start date.**

Current TST for previously negative reactors.

Date given _____ Date read _____ Results _____ mm
mm/dd/yy mm/dd/yy

Previous TST (**If it has been more than one year since your last TST, a second TST is required 7-14 days after the first TST).**

Date given _____ Date read _____ Results _____ mm
mm/dd/yy mm/dd/yy

[ ] IGRA TB blood test (T-Spot or Quantiferon Gold)

Date collected_____ Result_____ **Include a copy of lab report**
mm/dd/yy

[ ] If your TST is positive or you are known to have a positive TST or have/had a positive IGRA TB blood test (T-Spot or Quantiferon Gold) please provide the following:

Date of positive test _____ **Include a copy of the report**
mm/dd/yy

Chest x-ray completed no more than 6 months prior to start date.

Date _____ **Include a copy of report**
mm/dd/yy

C. HEPATITIS B:

If you have received the Hepatitis B vaccine, please indicate the following:

1. Dates of all vaccines received: 1) _____ 2) _____ 3) _____ 4) _____ 5) _____ 6) _____
2. Date of post –vaccine antibody testing _____ **Include copy of lab report**
   mm/dd/yy
3. [ ] Declined Vaccine

D. MEASLES (RUBEOLA), RUBELLA (GERMAN MEASLES), MUMPS:

If titers are drawn for any of the above, you must include a copy of the lab report.
If you received a single vaccine instead of an MMR, list vaccine and date given.

Dates of vaccine: (month/day/year)

Dose 1 _____
Dose 2 _____

E. VARICELLA (CHICKEN POX)

[ ] Dates of Vaccine: (month/day/year)

Dose 1 _____
Dose 2 _____

Or

[ ] **If you had chicken pox, you must provide proof of a positive varicella titer. <u>Must include a lab report.</u>**

F. Tdap (TETANUS, DIPHTHERIA and PERTUSSIS:

Date of vaccine: _____
mm/dd/yy

G. COLOR VISION:

Have you ever been tested for color blindness? [ ] Yes [ ] No
Do you have any color vision deficiency? [ ] Yes [ ] No
Date of color vision screening: _____
mm/dd/yy

Physician/Health Care Provider's Name (Print) _____

Address _____
Street **City** **State** **Zip**

Physician/Health Care Provider's Signature:

_____
Signature **Date** **Phone Number**

Please bring this completed form with you to your scheduled VCUHS Employee Health visit. Questions, please contact HR4U, 804-628-4748.