Cincinnati Children's
changing the outcome together

Health Screening Form for Non-CCHMC Personnel

Please complete the entire form (including contact information at the top) or we will be unable to accept this form.

Name (print):	**Date of Birth:**
Telephone number:	**Email:**

	1. I have had the following diseases/infections	**Yes**	**No**
a.	Measles		
b.	Varicella, Chickenpox, Shingles or Zoster **(circle those that apply)** **Year →** _____		
c.	Mumps		
d.	Hepatitis B, Hepatitis C, HIV, or other bloodborne pathogens		

	2. I currently have (or have had in the past year) the following signs or symptoms that might indicate infectious disease that I could transmit in the workplace (circle those that apply and comment on any Yes response)	**Yes**	**No**
a.	Unexplained Fever, night sweats, or weight loss (non-intentional)		
b.	Unexplained Cough of more than 2 weeks duration - with or without bloody secretions		
c.	Unexplained vomiting or diarrhea or bleeding		
d.	Recurrent boils, abscesses, or other skin infection		
*	Comment for **Yes** responses (diagnosis, any treatment and if ongoing):		

	3. In the past four weeks, I have been exposed to the following communicable diseases	**Yes**	**No**
a.	Measles		
b.	Varicella, Chicken Pox, Shingles or Zoster **(circle those that apply)**		
c.	Pertussis or Whooping Cough		
d.	Diphtheria		
e.	Ebola		
f.	MERS		
g.	Other (please list)		
*	Comment on any **Yes** response:		

	4. Tuberculosis	**Yes**	**No**
a.	I have been vaccinated with BCG. If **Yes**, when? **Year →** _____		
b.	Have you spent time with a person known to have active TB or suspected to have TB disease		
c.	I have had a "positive" tuberculin skin test (e.g., PPD) in the past. If Yes, indicate **Date:** _____**size** _____ **mm**		
d.	I have had active tuberculosis in the past Indicate **Date:**		
e.	I have taken anti-tuberculosis medications (e.g., INH) in the past Indicate **Date started**_____ **to Date finished**_____		
f.	If Yes to c., d., or e. above, when was your last chest x-ray? **Date →** _____		
*	Additional comments on any Yes response:		

	5. Travel	**Yes**	**No**
a.	Have you traveled to or had visitors/family members travel to/from the Arabian Peninsula in the past three weeks?		
b.	Have you traveled to or had visitors/family members travel to/from West Africa in the past three weeks?		
c.	I will be visiting the US from my home abroad. If Yes, from where? →_____		
d.	Have you traveled for vacation to a country where Tb disease is common for more than a 2 week period (e.g., Latin America, Caribbean, Africa, India, China, Southeast Asia, Eastern Europe, or Russia)? **(circle those that apply)** When?		
e.	Have you traveled for business to a country where Tb disease is common for more than a 2 week period? (e.g., Latin America, Caribbean, Africa, India, China, Southeast Asia, Eastern Europe, or Russia)		
f.	Have you traveled for work/service/volunteer to work with those in need in a country where Tb disease is common for more than a 2 week period? (e.g., Latin America, Caribbean, Africa, India, China, Southeast Asia, Eastern Europe, or Russia)		
g.	Work/Volunteer with those in need where TB disease is more common: Homeless shelter, migrant farm camp, prison or jail and some nursing homes? **(circle those that apply)**		
h.	Have you been associated with persons in a place where Tb disease is more than common such as a homeless shelter, migrant farm camp, prison or jail and some nursing homes?		
i.	Have you had visitors from countries where TB disease is common (most countries in Latin America and the Caribbean, Africa, India, China, Southeast Asia, Eastern Europe, and Russia) living in your home for more than 2 weeks? From where?_		

By signing below, I acknowledge that I have truthfully answered the questions above. By signing below, I acknowledge that, for the health and safety of Cincinnati Children's Hospital patients, visitors, and personnel, I should not participate in CCHMC activities if I have symptoms of a communicable disease (e.g., fever, cough, or rash illnesses) until those symptoms have resolved. If that condition lasts for > 2 weeks, I should notify Employee Health.

Signature _____ Date _____

CINCINNATI CHILDREN'S HOSPITAL MEDICAL CENTER
UNIVERSAL VACCINE INFORMATION

	YES		NO	Hypersensitive to bakers (bread) yeast?
	YES		NO	Acutely ill with fever in past 7 days?
	YES		NO	Severe life threatening allergic reaction to any vaccines in the past (difficulty breathing, swelling of lips or throat)? What vaccine? _____
	YES		NO	Is your cardiopulmonary system severely compromised?
	YES		NO	Are you pre-dialysis or on dialysis?
	YES		NO	Are you the recipient of a solid organ or bone marrow transplant?
	YES		NO	Immuno compromised? (current diagnosis or treatment of cancer, leukemia, lymphoma, HIV)
	YES		NO	Allergy to aluminum hydroxide, or preservatives 2 phenoxyethanol?
	YES		NO	History of severe latex allergy? Or latex sensitivity?
	YES		NO	History of Guillian-Barre Syndrome within 6 weeks of receiving a vaccine, history of epilepsy or nervous system diagnosis?
	YES		NO	Thrombocytopenia or bleeding disorder?
	YES		NO	Allergy to thimerosal other than in contact lense solution?
	YES		NO	Allergy to eggs?
	YES		NO	Currently pregnant? If yes, what is your due date? _____
	YES		NO	Allergic to neomycin?
	YES		NO	Allergic to gelatin?
	YES		NO	Taking long term immunosuppressive or steroid therapy or anti malarial agents.
	YES		NO	Received blood plasma in the past 5 months?
	YES		NO	Received immune globulin or Varicella Zoster immune globulin in the past 5 months?
	YES		NO	Previous coma or long seizure within 7 days of your last DTP or DTaP (this was the known cause)?

Further explain any yes answers and provide physician documentation:
_____
_____
_____
_____
_____

□ By signing below I acknowledge my responsibility in helping to create a safe environment by being free from *Preventable Contagious* tuberculosis and other communicable diseases. **I understand I should not participate in CCHMC activities if I have symptoms of a communicable disease** (fever, cough, rash) until the symptoms have resolved. I also understand that travel outside the United States places me at risk for infectious diseases if not properly immunized prior to leaving the country.

□ I authorize Cincinnati Children's Hospital Medical Center to release my medical record to myself during the dates of my employment. This authorization includes all records to include the use and/or disclosure of information concerning HIV testing or treatment of AIDS or AIDS-related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions to the above mentioned entity(s).

_____ _____
Employee Signature Date

Employee Health Review: _____ No action is required, approved for temporary badging.

Action required as follows: _____

_____ _____
Signature of Employee Health Nurse Date