Children's Hospital of Philadelphia

Effective Date: 04/11/2018

Job Aid: Immunization and TB Screening Record for Non-CHOP staff

Please print clearly

Name (Last, First, M.I.):	**Date of Birth**	**Today's Date**
Department/Program/Contractor:		
CHOP Work Location:	**Contact –**	

<u>All the information above must be completed in order to process this form.</u>
If you have any questions, contact the person at CHOP who is processing your hire (contract/affiliates), student internship or volunteer application. This form is NOT for employees on CHOP payroll.

All persons working with patients or families, or routinely working in a building where patients are seen, must provide proof of immunity as indicated below. This form must be signed by your healthcare provider, or alternatively you can attach your immunization and TB screening records.

MEASLES (Rubeola)

2 measles vaccines (measles or MMR) given after first birthday or positive blood titer

Immunizations & dates: Please check all that apply & date	☐ Measles Vaccine Date# 1:	☐ Measles Vaccine Date# 2
	☐ MMR Vaccine Measles, Mumps, Rubella Date # 1:	☐ MMR Vaccine Measles, Mumps, Rubella Date # 2:
	☐ Positive measles blood titer Date:	

MUMPS

2 mumps vaccines (mumps or MMR) given after first birthday or positive blood titer

Immunizations & dates: Please check all that apply & date	☐ Mumps Vaccine Date# 1:	☐ Mumps Vaccine Date# 2:
	☐ MMR Vaccine *Measles, Mumps, Rubella* Date # 1:	☐ MMR Vaccine *Measles, Mumps, Rubella* Date # 2:
	☐ Positive mumps blood titer Date:	

RUBELLA (German measles)

1 rubella vaccine (rubella or MMR) given after your first birthday or positive blood titer

Immunizations & dates: Please check all that apply & date	☐ Rubella Vaccine Date:	☐ MMR Vaccine *Measles, Mumps, Rubella* Date:
	☐ Positive rubella blood titer Date:	

Varicella (chicken pox)

Two vaccines given after your first birthday or positive blood titer

Immunizations & dates: Please check all that apply & date	☐ Varicella Vaccine Date# 1:	☐ Varicella Vaccine Date# 2:
	☐ Positive varicella blood titer Date:	

Tdap (Tetanus, diphtheria, and acellular pertussis)

Immunizations & dates: Please check all that apply & date	☐ Tdap Vaccine Date:

Influenza vaccine

(vaccine required for anyone working during flu season October 1 to April 30)

Immunizations & dates: Please check all that apply & date	☐ Influenza Vaccine Date:	Type of Vaccine ☐ Flu Shot ☐ Flu Mist

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Updated 08/25/2021

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TB Screening

Two step TB skin test is required. Specifically, a TB skin test recorded within the preceding year can be used for the "first step"; another recorded within 3 month of start date can be used for the "second step."

Note: students who are required to get TB skin tests for other rotations must have a PPD current within 1 year.

TB skin test #1 (must be within one year of start date)	Date:	Result: ___________ mm
TB skin test #2: (must be within 3 months of start date)	Date:	Result: ___________ mm
OR TB blood testing: (must be within 3 months of start date) **Name of Test:**	Date:	Result: ___________

For those with history of positive TB screening:

☐ Date of positive TB test _____________

☐ Attach the completed Tuberculosis Review Questionnaire

☐ Attach copy of post-conversion chest x-ray

☐ Indicate treatment received ____

Hepatitis B

(Complete this section if applicant will have potential exposure to human blood or body fluids)

Immunizations & dates: Please check all that apply & date	☐ Hepatitis B Vaccine Three Dose Series Date 1:	Date 2:	Date 3:
	☐ Hepatitis B Vaccine Two Dose Series Date 1:	Date 2:	
	☐ Positive Hepatitis B blood titer	Date:	
	☐ Declination: Applicant understands the risks regarding Hepatitis B virus and elects to decline the vaccine		

COVID-19

Mandatory for all as of 10/20/2021

PLEASE NOTE: COVID-19 vaccine proof must also be uploaded to https://redcap.link/COVIDVaxProof

Immunizations & dates: Please check all that apply & date	☐ Two Dose Series Manufacturer: _______________ Date 1: Date 2:	☐ One Dose Series Manufacturer: ________________ Date 1:

Healthcare Provider Name and Credentials: (Please print)		
Healthcare Provider Signature:		Date:
Office Name and Address:		

This completed form must be returned to the office that is processing the applicant's onboarding.

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Updated 08/25/2021