

## Dalhousie University Medical Surveillance Program Required Confidential Health History, Information, & Intervention

As part of the Dalhousie University Medical Surveillance Program, certain biohazardous materials require medical intervention as indicated in the Dalhousie Medical Surveillance Protocol (MSP). Where medical intervention is indicated, please ensure you complete and bring this form to your medical surveillance appointment. This form is secured in your confidential occupational health file.

Appointments can be scheduled by phoning IWK Health Centre, Occupational Health safety & Wellness at 902-470-7949.

**NAME:** \_\_\_\_\_ **DATE OF BIRTH:** \_\_\_\_\_  
*Last Name* *First Name* *(DD/MM/YY)*

### SECTION A – VACCINATION HISTORY

- This section is to be completed by a medical professional. It is the responsibility of the employee to obtain medical records from previous employers, schools, Public Health Services, or family physicians, in order to complete this form.

#### Physician Guide to Immunization Requirements / Infectious Diseases

Provide written confirmation of any of the following vaccinations, where applicable.

1. **Varicella** – Consider immune with evidence of physician diagnosed Varicella or shingles. If no history, show proof of immunity by blood test. If previous Varicella vaccine given, documentation of 2 doses as per Canadian Immunization Guide requirements.
2. **Tetanus-Diphtheria-Pertussis** – Documentation of a booster dose within the last 10 years.
3. **Measles, Mumps, Rubella** – Documented proof of immunity by blood test for each of the 3 diseases **or** documentation of 2 MMR's required.
4. **Tuberculosis** – If history of TB or treatment with INH, please indicate and provide CXR. If previous BCG vaccine has been given, provide documentation and any TST results post BCG. If the employee has had a 1 or 2-Step TST in the past, documentation is required. A 2-Step does not need to be repeated if documented. If no previous testing, OHSW will provide TST(s).
5. **Hepatitis B Vaccine** – Consider immune with documentation of 3 doses of vaccine **and** demonstrated immunity by HBsAg serology (Hepatitis B surface antibody level). If non-immune, follow Canadian Immunization Guide for follow-up. Provide documentation of any booster doses or total number of Hep B vaccines given if had more than one series.

Mandatory Requirements <i>(see below for guide)</i>	History Yes/No	Date Vaccine Given: (YYYY/MM/DD)	Serology Date (YYYY/MM/DD)	Serology Result
<b>Varicella</b> Chicken Pox		1. _____ 2. _____		
<b>TDaP</b> Tetanus/Diphtheria/Pertussis (Must be within 10 years & date documented)				
<b>MMR</b> Measles, Mumps, Rubella		1. _____ 2. _____		
<b>Hepatitis B</b>		1. _____ 2. _____ 3. _____		
<b>Tuberculosis</b>	<b>Test #1</b>		<b>Test #2</b>	

(YYYY/MM/DD)		(YYYY/MM/DD)	
<b>Result #1</b>	mm	<b>Result #2</b>	mm
<b>BCG Date:</b> (YYYY/MM/DD)		<b>CXR Result:</b> (YYYY/MM/DD)	

**Signature of Physician or OHN:**

Date (YY/MM/DD) :

## SECTION B - EMPLOYEE CONFIDENTIAL HEALTH RECORD

➤ This section is to be completed by the employee

Employment Date: (YY/MM/DD)	_____	Health Screening Date: (YY/MM/DD)	_____
Name: (First, Last)	_____	Date of Birth: (YY/MM/DD)	_____
Health Card Number	_____	Email:	_____
Street Address:	_____	Telephone:	_____
City, Province:	_____	Postal Code:	_____
Family Physician:	_____	Physician Phone:	_____
Department/Position:	_____	Work Phone:	_____

- Allergies (drugs, latex, other) \_\_\_\_\_
- Present health conditions under physician care: \_\_\_\_\_
- Present medications including over-the-counter and herbal medications: \_\_\_\_\_  
\_\_\_\_\_
- Past surgeries: \_\_\_\_\_
- Past medical conditions: \_\_\_\_\_  
\_\_\_\_\_
- Do you have any current conditions that may increase your risk of infection? \_\_\_\_\_  
\_\_\_\_\_
- Do you have any skin conditions? If yes, please explain and define if frequent handwashing aggravates the condition. \_\_\_\_\_
- Do you have any vision problems? If yes, please explain and define limitations, if any. \_\_\_\_\_  
\_\_\_\_\_
- Do you have hearing problems? If yes, please explain and define limitations, if any. \_\_\_\_\_  
\_\_\_\_\_

