PART A - CAREER EXPLORATION HEALTH QUESTIONNAIRE & ATTESTATION (1 of 3)

Student Information

Name _____

Address _____ City _____ State _____ Zip _____

Phone _____ Date of Birth _____

Section I:
To be completed by all applicants. (For chicken pox, rubella, rubeola and mumps, please refer to the exposure chart on page 2 to answer the following questions.)

Have you ever had varicella (chicken pox)?	☐ Yes	☐ No
Have you ever been exposed to anyone with chicken pox?	☐ Yes	☐ No
Have you ever had a varicella titer (test)? *We require that all volunteers born after December 1, 1956 provide proof of MMR vaccination.*	☐ Yes	☐ No
Have you ever had the MMR (measles, mumps, rubella) vaccine? If so when? _____	☐ Yes	☐ No
Have you ever had the German Measles (rubella)?	☐ Yes	☐ No
Have you ever been exposed to anyone with German Measles?	☐ Yes	☐ No
Have you ever had a rubella titer (test)? If yes, date and results _____	☐ Yes	☐ No
Have you ever had the Measles?	☐ Yes	☐ No
Have you ever been exposed to anyone with Measles?	☐ Yes	☐ No
Have you ever had a rubeola titer (test)? If yes, date and results _____	☐ Yes	☐ No

Section II: To be completed by all applicants
(PPD and Hepatitis B)

Have you ever had Hepatitis? If yes, date and type: _____	☐ Yes	☐ No
Have you ever been exposed to anyone with Hepatitis B?	☐ Yes	☐ No
Have you ever had the Hepatitis B vaccine? If yes, what are the dates of your vaccine? _____ _____ _____	☐ Yes	☐ No
Have you ever had the Hepatitis B surface antibody and antigen testing done? If yes, date and type: _____	☐ Yes	☐ No
Have you ever had tuberculosis (TB)? Did you receive treatment? _____ If yes, date and type of treatment: _____	☐ Yes	☐ No
Have you ever had exposed to anyone with TB? If yes, where and when: _____	☐ Yes	☐ No

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If yes, date and type of treatment: _____

Have you ever had a Mantoux (PPD/TB screening) test? ☐ Yes ☐ No
If yes, date :_____

What was the result of your PPD? Negative _____ Positive _____
If positive have you had a recent chest x-ray? ☐ Yes ☐ No
If yes what were the results? _____
If positive, please have your physician complete a Symptom Review Sheet
(This is available from the Occupational Health Department)

Have you ever had the Tdap vaccine (Tetanus/Diphtheria/Pertussis)? ☐ Yes ☐ No
If yes, what are the dates of your vaccine? _____ _____ _____

Exposure Chart for Diseases
Chicken Pox - Spending time with person 4-5 days before rash appears until days after rash appears.
German Measles (Rubella) - Spending time with person 7 days before rash appears until 4 days after rash appears.
Measles (Rubeola) - Spending time with person 4 days before rash appears until 3 days after rash appears.
Mumps - Spending time with person 6-7 days before swollen glands appear until 9 days after swollen glands appear.
Tuberculosis (TB) - Spending time with person with tuberculosis.
Hepatitis B - Direct contact with blood or bloody fluid from an individual with known and active Hepatitis B.

Influenza Declaration
In response to Joint Commission guidelines, effective December 1, 2018 all team members, student interns and volunteers in the hospital setting will be required to complete this form and provide proof of vaccination or wear a face mask for the duration of the time in the hospital. Adult volunteers may receive the vaccination through Hackensack Meridian *Health*. Student Interns and Juniors are responsible for receiving the vaccine through a private health practitioner.

Received the Vaccine Administration
☐ I received the vaccine through Hackensack Meridian *Health*

☐ I received the vaccine outside of Hackensack Meridian *Health* and attached documentation of this vaccination to the Volunteer Office. Documentation must include a note from the provider of the vaccine giving the date the vaccine was given and the name and address of the provider, or a detailed receipt identifying the same information.

Decline the Vaccine Administration
☐ Fear of Needles/Injections ☐ Fear of Side Effects ☐ Never Get Sick ☐ Religious Reason

☐ Severe allergic reaction after previous vaccine dose

☐ History of Guillian-Barre Syndrome within 6 weeks after a previous influenza vaccination

I understand that by declining the flu shot, I will need to wear a face mask at all times within the hospital facility between December 1st and March 31st.

I acknowledge that I am aware of the following facts:
*Influenza is a serious respiratory disease that kills an average of 36,000 persons and hospitalizes more than 200,000 persons in the United States each year.

*If I contract influenza, I will shed the virus for 24–48 hours before influenza symptoms appear. Shedding the virus can spread influenza disease to all people with whom I come in contact or those in close proximity to me.

*If I become infected with influenza, even when my symptoms are mild or non-existent, I can spread severe illness to others.

*I understand that the strains of virus that cause influenza infection change almost yearly, which is why an annual influenza vaccine is recommended each year.

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*I understand that I cannot get influenza from the influenza vaccine.

*I understand that my decision not to be vaccinated could have potentially life-threatening consequences to myself and others with whom I have contact.

Despite the information provided I am choosing to decline influenza vaccination right now. I understand:

*I may change my mind at any time and accept influenza vaccination, if vaccine is available.

*I will need to notify the Volunteer Office if at a later date I do choose to receive an influenza vaccination.

I have read, fully understand and will comply with the requirements on this form.

Section III: To be completed by all applicants

Are you currently under the care of a physician for any medical condition? ☐ Yes ☐ No

If yes, please indicate _____

Please list any known allergies _____

Signature of Applicant _____ Date _____

Signature of Facility Advisor _____ Date _____

Section IV: To be completed and signed by your physician.

I have reviewed the health history and the aforementioned Career Exploration Program applicant and the following holds true:

This individual is free from contagious disease ☐ Yes ☐ No

This individual is able to perform physical duties to tolerance ☐ Yes ☐ No

Limitations _____

Please list any medications that this patient is currently taking _____

Doctor's Name (please print or type) _____

Address _____

Doctor's Signature Date _____

Counselor please keep on file.