SCOTTISH RITE FOR CHILDREN

OCCUPATIONAL HEALTH REQUIREMENTS

The following clearance will be a requirement for staff members, volunteers, students and all hospital sponsored visitors.

These requirements can be attained by providing proof of actual immunization records from a doctor's office or blood lab result showing positive immunity to the following:

Influenza

1. Documentation of annual seasonal influenza vaccine by October 31st. Proof required ONLY during flu season (September-March).

Measles, Mumps, Rubella (MMR)

1. Documentation of 2 doses of live MMR vaccine given on or after the first birthday and separated by 28 days or more.
2. Laboratory confirmation of immunity.

Varicella

1. Documentation of 2 doses of varicella vaccine given at least 28 days apart.
2. Laboratory confirmation of immunity.

Tetanus/Diphtheria/Pertussis (Td/Tdap)

1. Documentation of 1 dose of Tdap and TD boosters every 10 years thereafter.

Hepatitis B

1. Documentation of 3 Hep B vaccines and or confirmation of immunity
2. Or signed declination statement if proof of a negative titer

TB screening

1. QuantiFERON gold blood test within 1 year of visiting for observers/visitors, and within 30 days from hire date for new staff. If test is positive, members must have a medical provider clear them from active TB. Clearance must include chest x-ray.

For additional information on these requirements please contact Occupational Health at 214-559-7809 or 8496.

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Occupational Health Clearance Form

***Please note document must be fully completed and copies of Immunizations or Titers must be attached**

Infectious Disease	Dates (DD-MM-YYYY)	Proof of Immunity
Measles	1. __-__-____ 2. __-__-____	Positive IgG titer date __ __ ____
Mumps	1. __-__-____ 2. __-__-____	Positive IgG titer date __-__-____
Rubella	1. __-__-____ 2. __-__-____	Positive IgG titer date __-__-____
Varicella	1. __-__-____ 2. __-__-____	Positive IgG titer date __-__-____
TetanusDiptheriaPertussis(TDAP)	__-__-____	
Tetanus (TD)every 10 years	__-__-____	
	__-__-____	
Influenza (seasonal)	__-__-____	
Tuberculosis	1. __-__-____ 2. __-__-____ } 2-52 weeks apart Result (circle one): Negative Positive	Blood assay for *M. tuberculosis* date __-__-____ Result (circle one): Negative Positive
Tuberculosis (all HCWs with positive history of TB or exposure)	Latent TB infection prophylaxis? Year ____ started or complete (circle one)	CXR date __-__-____ Result (circle one): Negative Positive
Hepatitis B (only applies to HCWs with potential occupational exposure to bloodborne pathogens)	1. __-__-____ 2. __-__-____ 3. __-__-____ If necessary (i.e., if first titer negative): 4. __-__-____ 5. __-__-____ 6. __-__-____	IgG (HBsAb) titer date __-__-____ Result (circle one): Negative Positive IgG (HBsAb) second titer date __-__-____ Result (circle one): Negative Positive Counseling provided date (if repeat titer negative) __-__-____
	__-__-____	

Name of Person Completing form: _____ Signature:_____

Phone Number: _____ Date: _____

HCP or coordinator has reviewed documentation and member has been found meeting all requirements.

Reviewer's signature _____ Name (print) _____ Date _____