KAISER PERMANENTE®
Medical Care Program
Southern California Region

HEALTH STATUS INFORMATION

According to the policy and procedures of Southern California Regional Human Resources (including HR 5.02) 22 CCR Section 7023, and CDC guidelines, all contracted medical center workers (e.g., registry and students) are required to demonstrate current immunity to the communicable diseases set forth in section 1.

1. Complete the following serology / immunization information:

Serologic immunity and/or up-to-date immunization is required. Enter date of titers and check box if immune or non-immune. If titer is negative or non-immune, MUST list immunization date(s). Give the last time immunized. The following number of doses are needed: 2 doses for rubeola, mumps, and varicella; 1 dose of rubella; and at least the first dose for Hepatitis B**,** or it can be declined in section 4. The first dose of MMR and/or varicella may be acceptable for clearance if the vaccine series was recently initiated (within last 30 days). The 2nd dose is mandatory per CDC schedule (28 days after 1st dose).

	Date of Titer	Immune	Non-Immune	Immunization Date(s)
Mumps				Dose #1: Dose #2:
Rubella				Dose #1:
Rubeola				Dose #1: Dose #2:
Varicella				Dose #1: Dose #2:
				Hx of disease: (circle one) Varicella or Shingles / Date diagnosed:
Hepatitis B				Dose #1: Dose #2: Dose #3:

Diagnosis of a history of chickenpox or shingles by a healthcare provider is acceptable for proof of varicella immunity.

2. Please answer the following questions by circling your response:

YES NO Have you had any new problem which **currently** is infectious or would prevent you from performing your assigned duties at this time? If "Yes", describe: ____________________

YES NO Have you had an unexplained weight loss in the last year? If "Yes", give amount lost: ____________________

YES NO Do you have a persistent cough (lasting 3 weeks or more)?

YES NO Do you cough up blood?

YES NO Do you have persistent, unexplained fevers or night sweats?

YES NO Do you have a rash? If "Yes", for how long? ____________________

YES NO Have you seen a doctor for any of the above? If "Yes", list which item(s) ____________________

3. Give the following tuberculosis screening information:

Provide date and result of 2 most recent TB skin tests or 1 IGRA (QFT or T-Spot). The last TST or IGRA needs to be within the last 12 months and "previous TST" needs to be within 2 years before starting work/rotation. A 2-step TST within a year is acceptable.

Last TST Date:	Result (mm of induration*)
Previous TST Date:	Result (mm of induration*)

Last IGRA Date:	Result:

IGRA result- indicate if positive or negative.

*Result should be in mm of induration for TST (i.e. "0" if no induration). If your TST/IGRA is newly positive, you will need to provide a report of a negative chest x-ray done after the TST/IGRA. If the TST/IGRA was previously positive, the results of a negative chest x-ray should be within 1 year of start date and on file at your registry/institution.

(If applicable): CXR Date:	Result:

4. Hepatitis B vaccine declination: I understand that due to my occupational exposure to blood or other potentially infectious material, I may be at risk of acquiring hepatitis B virus (HBV) infection. I understand by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease. If in the future I have an occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccination series through my agency/institution.
Sign if you want to decline the Hepatitis B vaccine. **Signature:** ____________________

5. Tdap Vaccine: Date of most recent vaccine or, if declining, circle Declination. **Date of Immunization: ____________ or Declination.**

6. Seasonal Flu Vaccination: Date of Immunization: ____________________ *Students must receive current season's flu vaccination or may not rotate in the medical center.

I hereby affirm that the information provided in this questionnaire is accurate and fairly represents my current health status. I understand that any misrepresentation, misstatement or omission in this questionnaire, whether intentional or not, shall constitutes a breach of contract between contractor, or contract agency, and Kaiser Permanente. Any such misrepresentation, misstatement or omission, whether intentional or otherwise, may result in immediate suspension or termination of employment or contracted work by Kaiser Permanente. I understand my employer/agency will receive a copy of this completed form.

Signature: ____________________ **Date:** ____________________

Print Name: ____________________ Date of Birth: ____________________

Address: ____________________ Zip: ____________ Phone: ____________

Department where rotating: ____________________ Rotation dates: ____________________

Name of Institution/Agency: ____________________

☐ **Resident** ☐ **PA Student** ☐ **Medical Student** ☐ **Observer in Training** ☐ **Registry** ☐ **Nursing Student** ☐ **Traveler** ☐ **Sub-Contractors**
☐ **Vendors/Contractors/Suppliers**