Volunteer Health Clearance Form

Please fill out form completely and <u>return with all required immunization records to your volunteer coordinator.</u> Any questions in regards to completion of this form, please contact Employee Occupational Health at 612-262-4490.

****Your social security number is required to process health clearance in the Allina Health System****

Name:_____ Previous Name(s):_____ SSN(required)_____

Date of Birth: _____ Phone Number (daytime): _____Email:_____

Volunteer Site: _____ Places you have lived outside USA: _____

PLEASE READ THROUGH ALL THE FOLLOWING QUESTIONS.
CHECK ALL ANSWERS THAT APPLY TO YOU.

Tuberculosis (TB)

_____I have never had a skin test or blood test for TB (Mantoux). (If you have never had a test, Allina will order proper testing free of charge as part of your on-boarding)
_____I have had a negative skin test for TB
_____Approximate date of last test (month and year) _____
_____I have received BCG vaccine (uncommon in U.S.)
_____ I have had a positive skin test or blood test for TB
_____ not treated _____treated with isoniazid (INH) or other medication
Dates of treatment: _____Duration of treatment_____
_____I have had TB
_____I have had a reaction (e.g. redness, swelling or bump) to TB skin test. If yes, describe:
_____

Current Health Status – Any current symptoms such as

____fever____cough over 3 weeks_____bloody sputum_____night sweats____weight loss____fatigue____poor appetite____unexplained chills
____chest pain

____No current symptoms

Mumps (Include a copy of proof of required vaccination if available)

_____I have had two Mumps vaccines. If yes, have documentation that you had it yes ☐ no ☐
_____I have been tested for Mumps antibody. Date _____
Was test: positive ☐ negative ☐ don't know ☐
_____I don't know if I have had Mumps or been vaccinated

Rubella (German Measles) (Include a copy of proof of required vaccination if available)

_____I had rubella vaccine. If yes, have documentation that you had it? yes☐ no ☐
_____I have been tested for rubella antibody. Date _____
Was test: positive ☐ negative ☐ don't know ☐
_____ I don't know if I have had German measles or been vaccinated

Measles (Rubeola) (Red Measles) (Include a copy of proof of required vaccination if available)

_____I have had Measles vaccine. If yes, have documentation that you had it yes ☐ no ☐
_____I have been tested for rubeola antibody. Date _____
Was test: positive ☐ negative ☐ don't know ☐
_____I don't know if I have had Measles (Rubeola) or been vaccinated

Chickenpox (Include a copy of proof of required vaccination if available)

_____I have had chickenpox (Varicella) vaccine.
If yes, do you have documentation of two vaccinations? yes ☐ no ☐
_____I have been tested for chickenpox immunity.
If yes, do you have documentation of lab titer results? yes ☐ no ☐
_____I don't know if I have had Chickenpox/and or shingles or been vaccinated

Tetanus / Diphtheria / Pertussis (Include a copy of proof of vaccination, if available)

_____ I had a primary series of 3 or 4 doses of DT, DPT, Td, or Tetanus vaccine
_____ Date of last tetanus vaccine "booster"
_____Date of last documented DPT vaccine
_____ I had a single adult does of Tdap vaccine
_____Date of documented Tdap vaccine
_____Allergy
_____Unknown

Hepatitis B (Include a copy of proof of vaccination, if available)

_____I have had Hepatitis B. If yes, date _____.
_____I have had the Hepatitis B vaccine. If yes, approximate dates:
Dose 1 _____ Dose 2 _____ Dose 3 _____ Dose 4 _____
Other (describe) _____
_____I have been tested for Hepatitis B antibody. If yes, date _____.
Where tested _____
Was test: positive ☐ negative ☐ don't know ☐
_____I have had Hepatitis B surface antigen test. If yes, date _____.
Was test: positive ☐ negative ☐ don't know ☐
_____I don't know if I have had Hepatitis or been vaccinated.

COVID Vaccine **(Include a copy of proof of vaccination if available)**

_____ I have NOT had the COVID vaccine.

_____ I have had the COVID vaccine(s). If yes, please include all dates you have received.

Vaccine Date 1:_____Manufacturer_____

Vaccine Date 2:_____Manufacturer_____

Vaccine Date 3:_____Manufacturer_____

Vaccine Date 4:_____Manufacturer_____

Vaccine Date 5:_____Manufacturer_____

Influenza Vaccine – **For current flu season (September-March). (Include a copy of proof of vaccination if available)**

_____ I have NOT had the Influenza vaccine.

_____ I have had the Influenza vaccine. If yes, date

Date:_____
Location received:_____

Applicant Name:_____

Immune Status: People with weakened immunity are at risk for more serious disease due to infection and may also pass infection more easily to others. ***Check if you have had the following:***

_____Uncontrolled HIV with CD4 count <200 or HIV patients not on antiretroviral medication
_____Currently receiving cancer treatment
_____With solid organ transplant on anti-rejection medication
_____Recent bone marrow transplant recipients with <500 absolute neutrophil count
_____With genetic immune deficiencies
_____On 30mg prednisone for 30 or more days
_____On immunosuppressants (mycophenolate, sirolimus, cyclosprine, tacrolimus, etanercept, rituximab, daclizumab, basiliximab, ocrelizumab, ofatumumab, obinutuzumab)

CONSENT:

VOLUNTEER NAME (Please Print): _____

VOLUNTER SIGNATURE _____DATE: _____

☐ By checking this box, I consent for a detailed voicemail to be left in regards to any type of follow up needed.

PARENTAL CONSENT **required if applicant under 18 years old:**

_____ DATE: _____
(*Parent/guardian signature*)

By signing above, you are consenting to have your child receive the necessary lab tests and/or immunizations in order to be cleared to work as a volunteer.

VOLUNTEERS please provide copies of all prior immunization records and/or lab titers listed below if you have available to you. Copies of your immunization record(s) should be sent along with this completed form to your volunteer coordinator. Record(s) may be obtained from the following sources: personal medical provider/public health clinic, the school district in which you attended grade school/high school, the college you attended, your parent/guardian. Please ensure your full name is visible on your documentation.

- **COVID**
- **Influenza**
- **TB skin test or QFT (TB blood test)**
- **Chest x-ray only if positive TB history**
- **MMR (Measles, Mumps, Rubella)**
- **Hepatitis B**
- **Tdap or TD**
- **Chicken Pox (Varicella)**

Blood tests that may be ordered are:

1. **Tuberculosis screening (QFT-Quantiferon Gold Test)**
2. **Immunity assessment to Measles, Mumps, Rubella, and Chicken Pox (varicella)**

See last page for location and hours of operation for Allina outpatient labs.

Applicant Name:_____

AUTHORIZATION TO ACCESS AND USE IMMUNIZATION RECORDS

As a benefit to you, Employee Occupational Health (EOH) will obtain your immunization information directly from state immunization registries on your behalf with your consent. If you would like to take advantage of this service, please complete the below Authorization to Access and Use Immunization Records form. Completing this authorization is not required for employment and/or volunteering, but without this authorization, you will need to obtain all of your immunization records on your own. If EOH does not receive your immunization records in a timely manner, your start date maybe delayed.

I, _____, understand that I am required to provide immunization records for required immunizations to Allina Health System ("Allina Health") as a condition of employment and/or volunteering at Allina Health to protect patients, health care workers, visitors and the community. Allina Health's Employee Occupational Health Department provides a service to Allina Health employees and volunteers by offering and coordinating immunizations for Allina Health employees and other workforce members. To aid in this process, I authorize Allina Health and its Agents to obtain immunization information for me on my behalf from state immunization registries, including, but not limited to, the Minnesota Immunization Information Connection (MIIC) and the Wisconsin Immunization Registry (WIR).

First and Last Name: _____

Signature: _____

Signature of Parent/Guardian(Parental Consent is required if under 18 years old): _____

Date of Birth (MM/DD/YYYY): _____

Date: _____

This consent will continue forever unless I cancel it in writing by:
Email
employeeoccupationalhealthserv@allina.com
OR
By Mail:
Employee Occupational Health
3960 Coon Rapids Blvd NW
Suite 315
Coon Rapids, MN 55433

If I cancel my consent, it will not apply to releases that have already been made.

☐

I decline to authorize Allina Health to obtain information for me on my behalf from state immunization registries.

Allina Health LAB Locations

Location	Hours	Directions
Abbott Northwestern Hospital 800 E 28th street Minneapolis MN 55407	**M – F:** 6am-6pm	Follow signs to ED. In hallway, Emergency is written on wall, take a left in that hallway (not right to the ED) to the check in desk. (across from ED)
Abbott Northwestern Center for Outpatient Care – EDINA 8100W.78th St Suite 110 Edina, MN 55439	**M-F** 8am-4:30pm ***Call For Appointment*** *952-914-8046*	Enter through main entrance and follow sign to Suite 110. (On main floor)
Buffalo Hospital 303 Catlin St Buffalo, MN 55313	**M – F:** 7am-5pm **Sat/Sun:** 9am-5:00pm ***Call For Appointment*** *763-684-7855*	Enter main entrance, turn right at gift shop. Go past Imaging/Radiology, turn left at next hallway. Lab halfway down the hall on the left side.
Cambridge Medical Center 701 S. Dellwood St. Cambridge, MN 55008.	**M – F:** 7am-5:00pm **Sat/Sun:**9am-5:00pm	Enter main entrance. Lab is located right behind the information desk.
Faribault Medical Center 200 State Ave Faribault, MN 55021	**M – F:** 8am-1:30pm	Enter main entrance under sign "Faribault Medical Center", walk past gift shop to front desk. Check in at front desk, will direct you to lab.
Mercy Hospital 4050 Coon rapids Blvd NW Coon Rapids, MN 55433	**M – F:** 7am-5pm **Sat:** 7am-1pm	Enter through the main doors - near the ED. Lab will be next to ED.
Mercy Hospital- Unity Campus 550 Osborne RD NE Fridley MN 55432	**M – F:** 7am-5pm **Sat:** 7am-1pm	Enter through main doors. Take the first hallway on the left, you will see signs for lab.
New Ulm Medical Center 1324 Fifth North Street New Ulm, MN. 56073	**M – F:** 7am-5pm **Sat:** 8am-9am ***Call For Appointment*** *507-217-5366*	Enter main hospital entrance (not clinic or ED entrance). Turn right into hallway directly behind circular front desk. Follow hallway straight until you reach lab on the left-hand side. Check in at lab desk.
Owatonna Hospital 2250 NW 26th St Owatonna, MN 55060	**M – F:** 8am-1:30pm *Report to Emergency Room Registration Desk*	Enter door 1 under the red Emergency Department sign. Check in at the front desk, they will direct you to lab.
United Hospital – Hastings Regina Campus Nininger Rd Hastings MN 55033	**M – F:** 8am-2:30pm	Enter through main doors next to Emergency Department entrance. Check in at front desk, they will direct you to lab.

Allina Health LAB Locations

River Falls Area Hospital 1629 Division St. River Falls WI 54022	**M – F:** 8am-1:30pm	Enter through main doors and check in at front desk, they will direct you to lab.
St. Francis Medical Center 1455 St. Francis Ave Shakopee, MN 55379	**M – F:** 6am-4:15pm **Sat/Sun:** 7am-11am	Enter through main entrance. Check in at patient registration, they will direct you to lab.
United Hospital 333 Smith Avenue North St Paul MN 55102	**M – F:** 6am-6pm **Sat:** 7am-1:30pm	Park in Blue Ramp, directly across the street from the main entrance. Enter main entrance and check in at welcome desk, they will direct you to lab.
ANW West Health 2855 Campus Dr Suite 215 Plymouth, MN 55441	**M – F:** 7:30am-4:30pm	Enter main entrance to elevators on your left. Go to 2nd floor, take a right when exiting elevator.