KAISER PERMANENTE®
Medical Care Program
Southern California Region

HEALTH STATUS INFORMATION

Print Name:	**Date of Birth:**
Name of Institution/Agency:	

Assignment/Rotation Details:

KP Location: _____ **Department:** _____

Assignment/Rotation Dates: _____to_____

Select from one of the options below:

☐ Resident ☐ PA Student ☐ Medical Student ☐ Nursing Student ☐ Pharmacy Student

☐ Observer in Training ☐ Registry/Locum ☐ Traveler ☐ Sub-Contractor ☐ Vendor/Supplier

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 and 2, and comply with TB screening set forth in section 3.

1. Measles, Mumps, Rubella, Varicella 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 most recent immunization date(s). The following number of doses are needed: 2 doses for rubeola, mumps, and varicella; 1 dose of rubella. The first dose of measles, mumps, rubella (MMR) and/or varicella vaccine 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).

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

	Date of Titer	Immune	Non-Immune	Immunization Date(s)		
Rubeola				Dose #1:	Dose #2:	
Mumps				Dose #1:	Dose #2:	
Rubella				Dose #1:		
Varicella				Dose #1:	Dose #2:	History of disease (**choose one**): ☐Varicella or ☐Shingles Date diagnosed:

2.A. Hepatitis B immunization information:

Record of complete vaccine series AND post vaccination positive lab result/titer OR signed declination in section 2B. Individual dose(s) may be acceptable for clearance if vaccination is recent as part of completing a full series. Complete series = 2 doses or 3 doses depending upon formulation.

	Date of Titer	Immune	Non-Immune	Immunization Date(s)			**Formulation** (if known):
Hepatitis B				Dose #1:	Dose #2:	Dose #3:	☐ Engerix/Recombivax ☐ Heplisav-B

2.B. Hepatis 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 declining the Hepatitis B vaccine. **Signature:** _____**Date of Declination:** _____

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3.A. Tuberculosis Symptom Screening - Please answer the following questions:

Do you currently have any of the following symptoms lasting more than 3 weeks, unrelated to confirmed COVID-19 or Influenza infection?

Persistent cough?	☐ YES ☐ NO	Coughing up blood?	☐ YES ☐ NO
Unexplained excessive weight loss or loss of appetite?	☐ YES ☐ NO	Unexplained excessive fatigue or weakness?	☐ YES ☐ NO
Unexplained excessive night sweat?	☐ YES ☐ NO	Persistent fever?	☐ YES ☐ NO

3.B. Tuberculosis Screening Information:

Provide date(s) and result of 2 most recent TB skin tests (TST) 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.

Most recent TST Date (within 12 months):	Result (mm of induration*)
Previous TST Date (within 2 years):	Result (mm of induration*)

Last IGRA Date (within 12 months):	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 institution/agency.

(If applicable) CXR Date:	Result:

4.Tdap Vaccine: List date of recent vaccine within past 10 years.

Date of Immunization: _____ ***OR*** **Sign if Declining:** _____ **Date of Declination:** _____

5. Seasonal Flu Vaccination: Seasonal flu vaccination available August of current year through April of the following year.

Date of Immunization: _____ ***OR*** **Sign if Declining:** _____ **Date of Declination:** _____

** Masking mandate will be enforced (where applicable) during respiratory virus season (November through April) if current seasonal flu immunization is ***NOT*** yet received ***OR*** if vaccine is declined.

6. COVID-19 Vaccination: Most current formulation of COVID-19 vaccine available as of September of current calendar year.

Date of Immunization: _____ ***OR*** **Sign if Declining:** _____ **Date of Declination:** _____

** Masking mandate will be enforced (where applicable) during respiratory virus season (November through April) if current COVID-19 immunization is ***NOT*** yet received ***OR*** if vaccine is declined.

Attestation: 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: _____

Address: _____ **Zip**: _____

Phone: _____ **Email**: _____