

Employee Health Information

Employee name	Employee number	10005945	Date of birth
Previous RCH ID #	Start Date		email
Position title	Department		RCH email

Hepatitis B

Have you had the Hepatitis B **vaccine**:

- 3 doses Yes No
 2 doses Yes No
 Booster dose Yes No

Provide serology result

Measles, Mumps, Rubella (MMR)

Have you had the MMR **vaccines**:

- 2 doses Yes No
 1 dose Yes No

Have you had the **disease**:

- Measles Yes No
 Mumps Yes No
 Rubella Yes No

Provide evidence of vaccine or serology (if born after 1966)

Hand Hygiene – only complete if you have direct patient contact

Do you currently have any type or degree of skin problem on your hands, wrists, or forearms? Do

you have any proven skin allergies (e.g. by patch testing) on your hands, wrists, or forearms?

Do you ever need to wear a brace, splint, or compression garment on your hands, wrists, or forearms at work?

If you answered yes to any of the above, please provide more detail on the reverse of this form.

- Yes No
 Yes No
 Yes No

Office use only

Date received	Date emailed	Needs
Date entered SAP		Signature

Chickenpox (Varicella)

Have you had the chickenpox **disease**? Yes No

If not had **disease** had the chickenpox **vaccine**? **Provide evidence of vaccine**

- 2 doses Yes No
 1 dose Yes No
 Unsure Yes No

Diphtheria, Tetanus, Pertussis

Have you had the childhood **DTPa vaccines** Yes No Unsure

Have you had an adult booster of **dTpa**? Yes No Unsure

Date of last vaccine: ____/____/____ (e.g. Boostrix or Adacel)

Provide evidence of vaccine

Annual influenza vaccine

Date of last vaccine: ____/____/ ____

***Provide photocopied
evidence of past
vaccination/blood tests***