Employee Health Information

Employee name	first lastname	Employee number	(if known) xxxxxxxxxxx 10005945	Date of birth	dd/mm/yy
Previous RCH ID #	(if prev employed)000000	Start Date	00/12/2020	email	XX@XXX
Position title	craft group	Department	XXXX	RCH email	(if known)XXX

Hepatitis B

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

3 doses	☐ Yes	☐ No
2 doses	☐ Yes	☐ No
Booster dose	☐ Yes	☐ No

Provide serology result*

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

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)

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: dd / mm / yy (e.g. Boostrix or Adacel)

Provide evidence of vaccine*

Annual influenza vaccine

Date of last vaccine: / /

dd mm / yy

Provide copies evidence of past vaccination/blood tests

COVID-19 vaccines evidence*

Date of vaccines: X/XX/2021 X/XX/2021

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?	☐ Yes	☐ No
Do you have any proven skin allergies (e.g. by patch testing) on your hands, wrists, or forearms?	☐ Yes	☐ No
Do you ever need to wear a brace, splint, or compression garment on your hands, wrists, or forearms at work?	☐ Yes	☐ No

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

Office use only

Date received		Date emailed	Needs
Date entered SAP			Signature

How to get an immunisation history statement - Services Australia
click here for the Immunisation history website.