PROVIDENCE Healthcare

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Occupational Health, Safety and Wellness Questionnaire for New Volunteers

- Complete **Section A** below and bring this form to your interview.
- Parents/guardians of applicants 14 to 17 years old, must complete and sign the consent information on the reverse side of this form, if your child is to have the TB test done at Providence Healthcare.
- If testing is being conducted outside of Providence, please bring documentation with you to your interview .

Section A (To be completed by all applicants)

Last Name	Given Name	Date of Birth
Telephone	Address	
In case of an emergency contact	Relationship	Telephone

Do you have any allergies? ☐ No ☐ Yes If yes, what are you allergic to? _____

Do you have any medical condition that could affect your ability to perform your tasks at Providence Healthcare?

☐ No ☐ Yes Explain: _____

Presently, do you suffer from a persistent cough (lasting more than 3 weeks) associated with bloody sputum, night sweats, weight loss, loss of appetite or fever? ☐ No ☐ Yes

Have you ever had Chickenpox? ☐ No ☐ Yes ☐ Not sure

Have you ever had Tuberculosis? ☐ No ☐ Yes Date: _____

Have you ever received a vaccine against tuberculosis (BCG)? ☐ Don't Know ☐ No ☐ Yes Year:_____

Date of last tuberculin test: _____ Reaction: _____ mm induration

If positive, did you follow-up with your doctor? ☐ No ☐ Yes
Explain:_____

Date of your last Chest X-Ray: _____Result: _____

Section B (to be completed by Occupational Health, Safety and Wellness Nurse)

NOTE: Doctor's stamp is required if test completed outside of Providence Healthcare

NOTE: TWO-STEP TUBERCULOSIS TEST REQUIRED (DONE WITHIN PAST 6 MONTHS)

1st step TB test (PPD 5TU): Date given _____ Site _____ Lot # _____ Given by_____

Date read: _____ Result _____ mm induration Read by _____

2nd step TB test (PPD 5TU): Date given _____ Site _____ lot #_____ Given by _____

Date read _____ Result _____ mm induration Read by _____

If TB skin test is positive, a recent chest x-ray result is required (CXR done within past 3 months):

Date of CXR: _____ Result: _____

OHN to refer volunteer to family doctor if TB skin test positive. Date referred to FD _____

Referred by _____

IF YOU ARE UNDER 18 YEARS OF AGE,
PLEASE HAVE YOUR PARENT OR GUARDIAN SIGN THE CONSENT ON THE BACK OF THIS FORM.

Parental/Guardianship Consent

I (we) being the parent(s)/guardian/custodian of: _____ do hereby authorize the Occupational Health, Safety and Wellness department of Providence Healthcare to administer a two-step TB skin test for the above-named, and liaise with the family doctor of the above-named regarding follow-up in the event of a positive TB skin test result.

PLEASE PRINT

NAME: _____

ADDRESS: _____

RELATIONSHIP: _____

SIGNATURE: _____

DATE: _____

Tuberculosis (TB) Skin Test

Department: Occupational Health, Safety and Wellness Room: D207

Office Hours: Monday – Friday
8:00 am – 4:00 pm

** ***NO TB test will be performed on Thursdays; or Fridays of a long weekend.***

Applicant: An appointment has been booked for you immediately following your interview, if you wish to get your TB test started at Providence.

Youth Applicants: If you wish to have your TB test done at Providence, you must have your parent/guardian complete the above form and bring it with you to your interview/appointment. The test cannot be done without this consent.

Important Notice: *You must return within 48 – 72 hours after receiving the TB injection to have the results read (e.g. if you get a TB test on Monday, you **MUST** come back on Wednesday, or Thursday at the latest to have your results read by one of the nurses in Occupational Health, Safety and Wellness. If you do not, you will have to start over again.*

For questions, please call (416) 285-3666, Ext 4025.