RUNNYMEDE
HEALTHCARE CENTRE

We make it possible.

Dear Medical Professional:

To enable your patient to participate in the volunteer program at **RUNNYMEDE HEALTHCARE CENTRE,** please provide the information requested.

In accordance with the Ontario Hospitals Associaiton Communicable Disease Surveillance Protocols, please provide the following:

Please provide dates of immunization, including year, for Varicella, Measles, Mumps and Rubella. If blood titers are taken ***a copy of the lab results*** are to accompany this form.

The Tuberculosis Skin Test is a 2 – step test. Both step 1 and step 2 are required. If after step 1 the induration is greater than > 10 mm, a chest x-ray is required and ***a copy of the x-ray results*** are to accompany this form.

During Influenza season we urge volunteers to receive the flu shot. Please document date of receipt of influenza vaccine on the attached form. Please also note if your patient declines the influenza vaccine.

Please contact the Occupational Health Department at 416-762-7316 ext. 2257 should you have any questions or concerns.

Regards,

Occupational Health Department
Runnymede Healthcare Centre

RUNNYMEDE
HEALTHCARE CENTRE

VOLUNTEER SERVICES – IMMUNIZATION HISTORY

Name: ______________________________ D.O.B. ____________________

E-mail: ______________________________ Phone: ____________________

Address: ______________________ City: ______________ Postal Code: __________

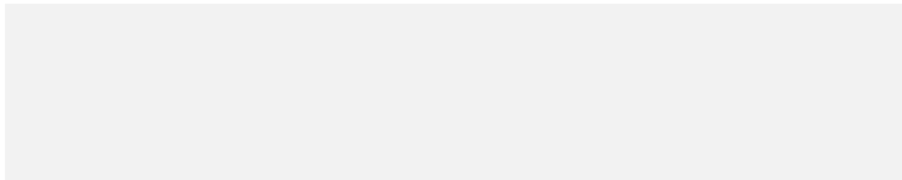
Tuberculosis Skin Test Step 1: Date given ____________ Date read ____________ Mm Induration ____________ Result ____________ Step 2: Date given ____________ Date read ____________ Mm Induration ____________ Result ____________ *OR* Chest X-Ray Date: ____________ Result: ____________	
Measles Laboratory evidence of immunity ***or*** 2MMR vaccines in life time.	☐ Immune ☐ Not Immune / Indeterminate / Unknown ***or*** 1. MMR Vaccine Date: _________ 2. MMR Vaccine Date:___________
Mumps Laboratory evidence of immunity ***or*** 2 MMR vaccines in life time	☐ Immune ☐ Not Immune / Indeterminate / Unknown ***or*** 1. MMR Vaccine Date: _________ 2. MMR Vaccine Date:___________
Rubella Laboratory evidence of immunity ***or*** 2 MMR vaccines in life time	☐ Immune ☐ Not Immune / Indeterminate / Unknown ***or*** 1. MMR Vaccine Date: _________ 2. MMR Vaccine Date:___________
Varicella/Zoster (chickenpox) Laboratory evidence of immunity ***or*** 2 Varicella vaccines in life time	☐ Immune ☐ Not Immune / Indeterminate / Unknown ***or*** 1. MMR Vaccine Date: _________ 2. MMR Vaccine Date:___________
Tetanus/Diphtheria /Pertussis Pertussis vaccination (dTap) REQUIRED once as an adult Td every 10 years recommended	☐ dTap (Adacel) Date: ______________ ☐ Td Date: ______________
Influenza Vaccination Recommended annually during influenza season	Date declined:______________________________ OR Date received:______________________________

Volunteer's Signature ______________________________ Date ____________________

Parent/Guardian (Under the age of 16) ____________________ Date ____________________

Physician Signature ______________________________ Date ____________________

Physician Stamp (REQUIRED)



The personal information requested on this form is necessary for the proper administration of a lawfully authorized activity and as applicable, is collected in accordance with subsection 38(2) of the Freedom of Information and Protection of Privacy Act (FIPPA), R.S.O. 1990, c.F31. The information provided will be used for administration of the Volunteer Department including communicating with the volunteer and assessing suitability for a volunteer position at Runnymede Healthcare Centre.