



THE QUEEN ELIZABETH HOSPITAL BOARD

MARTINDALES ROAD, ST. MICHAEL, BB 11155, BARBADOS, W.I.



VOLUNTEER HEALTH SCREENING FORM

Important Notice

- This Volunteer Health Screening form MUST be thoroughly completed by ALL volunteers prior to the assumption of responsibilities.
- Please forward this form and supporting documents under confidential cover through the Occupational Safety, Health and Wellness Section (OSHWS) of the Human Resources Department for submission to the QEH Staff Wellness Centre.
- Sections I and II must be completed by the Volunteer.
- Section III must be completed by your Family Physician or General Practitioner.
- Section IV must be filled out by the Hospital Infection Control Unit.
- Copies of your immunization documents must be provided on submission of this form.

All sections must be completed. Incomplete forms will be returned.

SECTION I - PERSONAL DATA

Title: Dr/ Mr/ Mrs/ Ms/ Miss

Surname: First Name:

Sex: Male/ Female Date of Birth:

Address:

Telephone number: Home: Mobile:

Email Address: Placement Area:

SECTION II - PERSONAL MEDICAL HISTORY

Kindly state if you suffer from or have been treated for the following conditions listed below:

Conditions	Response	
Dizziness, fainting, convulsions	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Headaches	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Asthma, shortness of breath, bronchitis, other respiratory disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Chest pains, high blood pressure, cardiac disorders	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Allergies	Yes <input type="checkbox"/>	No <input type="checkbox"/>

Are you currently taking any prescribed medication? Yes No

If yes, kindly state:

Do you have a disability or special needs? Yes No

Kindly state if you require special aids or assistance:

DECLARATION

I hereby declare that the information provided is true and complete. I understand that any information proven to be deliberately omitted or any statement shown to be false within my knowledge, that I may be disqualified from volunteering. I agree to comply with all required immunization checks and health screening deemed mandatory prior to volunteering at the QEH, which is classified as a high risk environment.

Signature: Print Name:

Date:

SECTION III - IMMUNIZATION HISTORY

This section must be filled out by your Family Physician/ General Practitioner. Physicians can refer to page 7 of this document for clarification.

IMMUNIZATION	YES	NO	DATE(S)	TEST RESULTS
Measles/Mumps/Rubella				
BCG				
Hepatitis B				
Varicella (Chicken Pox)				
DPT				
Diphtheria & Tetanus				
Mantoux (TB Test)				

I certify that the above information is complete and accurate and supporting documents have been presented to verify such.

Signature of Medical Practitioner

Print Name

Date:

SECTION IV - MASK FIT TESTING

RESPIRATOR/MASK FIT FORM

Name of Volunteer: _____
PLEASE PRINT (SURNAME) (FIRST NAME)

Placement Area: _____

Instructions:

- Respirator/mask fit data is valid for 2 years
- Please complete this form or forward copies of your respirator/mask fit cards to the OSHWS of the Human Resources Department
- Appointments can be made through the HICU at Ext: 6115
- Please refer to Exemption Form if exemption is required

RESPIRATOR/MASK FIT DATA:

Date Fitted: _____ Brand: _____ Size: _____

Quality of Fit: _____ Expiration Date: _____

(Pass/Fail) (Default = 2 years)

Hospital/Site of Fit Test: _____

Comments: _____

Clinic/Health Centre Authorization:

I certify that the above information is complete and accurate.

(Name, address and phone number of centre where form completed)

Signature of Healthcare Professional

Printed Name

Date: _____

Date for Review:

SECTION IV - MASK FIT TESTING CONTINUED

N95/RESPIRATOR MASK FIT TESTING EXEMPTION FORM

NAME: _____
PLEASE PRINT (SURNAME) (FIRST NAME)

Placement Area: _____

I am aware that I am not mask fit tested and will not be permitted to participate in any rotation/training that requires the use of N95/Respirator masks in the hospital for the following reason(s):

- Religious/ Cultural
- Medical Condition
- Other, please specify: _____

If for any reason I am exposed to airborne infectious agents, I will seek immediate medical attention and report the incident to the Occupational Health Section/Staff Clinic.

In the event of a pandemic, I understand that I am restricted from participating in any clinical activity and from being present in any hospital setting that may expose me to any airborne contaminants.

If there is any change to my status, I will notify the Queen Elizabeth Hospital Board to facilitate the update of my mask fit exemption status.

Date for Review:

I hereby declare that the foregoing is true and I understand that should any statement be shown to be false within my knowledge, I may be liable to disqualification from volunteering.	
_____ Signature of Volunteer	_____ Print Name
Date: _____	

SECTION V - MEDICAL ASSESSMENT RECOMMENDATION

For Official Use by the Staff Wellness Centre, QEH ONLY:

Having reviewed the attached Volunteer Health Screening Form this department concludes that this individual is:

- Fit to volunteer
 - Awaiting further medical assessment
 - Unfit to volunteer
-

REFERRAL

This individual has been recommended for further vaccination as follows:

- Appointment with Dr _____, Department of _____
- Appointment with Nurse, _____, Department of _____

APPOINTMENT REASON

- Mantoux test BCBG vaccination/ scar check Varicella update
- Hepatitis B update MMR update Review appointment
- Other: _____

SECTION IV (FOR OFFICIAL USE ONLY)

I hereby certify that I have examined and confirm that he/she:

- is fit for volunteering at The Queen Elizabeth Hospital
- should undergo a further medical examination for reasons stated separately.

Signature of Medical Referee/Physician

Print Name

Date:

Instructions to Physician completing Volunteer Immunization Form

IMPORTANT

The applicant's immunization record MUST NOT be completed without evidence of immunity or written documentation as defined below:

TUBERCULOSIS

- A 2-step Mantoux must be done at the time of initial registration if last documentation TB skin test is negative;
- Please note: BCG vaccination (s) does not preclude TB skin testing and chest x-rays are not alternative to TB skin test;
- Chest x-ray results are required with positive TB skin test or assay;
- Gamma interferon assay (not widely available) may be done as an alternative to skin test.

HEPATITIS B:

- Lab evidence of immunity (anti-HBs) is required with provision of the date;
- HBsAg (antigen) must be screened if no prior history of immunization or if lab evidence of immunity is negative;
- If HBsAg is positive, HBeAg (e-antigen) must be screened;
- Immunization dates along with lab evidence of non-immunity are required for those who have not developed antibodies after the 2nd immunization series.

MEASLES/MUMPS/RUBELLA:

- Lab evidence of immunity with date, or
- Documentation of receipt of **two (2)** vaccines on or after their first birthday
- **Born before 1970.**

VARICELLA/SHINGLES

- **Documentation** of definite disease history, or
- Lab evidence of immunity (VZV antibody) with date, or
- **Documentation** of receipt of two (2) varicella vaccines with dates

Immunization against the following is STRONGLY RECOMMENDED:

- **Diphtheria and Tetanus – boosters every ten (10) years**

Immunization against the FLU is STRONGLY RECOMMENDED.
