



# Job Shadow Health Screening

COMPLETE and RETURN form prior to the job shadow experience.

Job Shadow Participant (printed name): \_\_\_\_\_

Metro Health Shadowing Location: \_\_\_\_\_

<u>HEALTH RELATED REQUIREMENTS</u>	<u>Vaccination Dates</u>	<u>Test Dates &amp; Results</u> (TB test, lab titers, chest x-ray with history of positive TB test)	<u>Other</u> (Details, history or exempt due to date of birth)
<p><b>TB Screening</b></p> <p><input type="checkbox"/> Proof of a negative TB test <u>within the past year</u></p> <p style="text-align: center;"><b>OR</b></p> <p><u>If you have not a TB test within the past year</u>, complete the following:</p> <div style="border: 1px solid black; padding: 5px; margin: 5px 0;"> <p>Please check YES or NO to the following questions. Give details in "Other" column for any "Yes" answers. <b>Anyone who currently is symptomatic ("Yes" answers to items A-F) may not job shadow until symptom free and cleared by his or her physician.</b></p> </div> <p><b>In the past year, have you had:</b></p> <p>A. Unaccountable weight loss      <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>B. Onset of chronic cough            <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>C. Coughing up of blood                <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>D. Chest pain on breathing             <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>E. Night sweats                            <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>F. Unaccountable fever                  <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>G. A chest x-ray                            <input type="checkbox"/> Yes    <input type="checkbox"/> No</p> <p>If YES, detail when and why you had the x-ray in "Other" column.</p>	<p>Not Applicable</p>		
<p><b>Rubeola and Rubella</b> (<i>If born in or after 1957</i>)</p> <p><input type="checkbox"/> 2 MMRs on or after first birthday (documentation of specific dates required), <b>OR</b></p> <p><input type="checkbox"/> Lab titer showing immunity to Rubeola and Rubella</p>	<p>Enter the <u>two</u> vaccine dates here</p>	<p>Enter the lab titer date &amp; results here</p>	
<p><b>Chicken Pox (Varicella)</b></p> <p><input type="checkbox"/> History of having had the disease, <b>OR</b></p> <p><input type="checkbox"/> Lab titer showing immunity, <b>OR</b></p> <p><input type="checkbox"/> Documentation of 2 VARIVAX® vaccinations</p>	<p>Enter the <u>two</u> vaccine dates here</p>	<p>Enter the lab titer date &amp; results here</p>	<p>Enter the date you had chicken pox here</p>

I verify that the information provided is accurate and hard copy documentation of items listed are on file and available upon request.

Signature & title of person completing this form: \_\_\_\_\_ Date: \_\_\_\_\_

**Anyone who is not immune to Chickenpox, Rubeola or Rubella may not job shadow in a clinical area.  
Anyone who is symptomatic for TB or any respiratory virus may not job shadow in any area of the hospital.**