



**AmeriCares Free Clinics**  
**88 Hamilton Avenue**  
**Stamford, CT 06902**  
**(203) 658-9592 Fax: (203) 658-9612**  
**freeclinics@americares.org**

It is the desire of the AmeriCares Free Clinics to protect its patients and staff from communicable diseases. As a clinic employee or volunteer, you are required to complete this form.

**PART 1**

To the best of your knowledge, please provide specific dates (day/month/year) of physician-documented illness, titer or date of immunization for the following:

**Communicable Disease History and Immunizations**

	<b>Had Illness</b>			<b>Immunized</b>			<b>Date (most recent)</b>
	Yes	No	Unsure	Yes	No	Unsure	
Rubella (German Measles)							_____
Rubeola (Red Measles)							1. _____
(2 doses required if born in/after 1957)							2. _____
Chicken Pox							_____
Polio							_____
Tetanus/Diphtheria booster							_____
BCG (vaccine for TB)							_____
Influenza Vaccine							_____

Have you received **Hepatitis B** vaccine? Yes No Dates: #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_  
 Anti Hbs titer drawn? Yes No Date: \_\_\_\_\_ Result: \_\_\_\_\_

The Hepatitis B vaccine series will be made available at no cost to volunteer medical staff who, due to exposure to blood or other potentially infectious materials, may be at risk of acquiring the Hepatitis B virus infection. Of note, if you are drawing blood in the Norwalk Clinic, you must have the Hep B vaccine series. However, if you have another source through which you can obtain the series, please do so. If you have not had the series and choose not to receive the vaccine series, this form will serve to document your declination of the vaccine series.

Initial \_\_\_\_\_

Have you been exposed to blood or body fluids in the course of your work, through needle-stick/sharps injuries or mucous membrane exposure? Yes No Date(s): \_\_\_\_\_  
 If yes, have you been tested for HIV and counseled regarding the proper follow-up? Yes No  
 If you are aware of any communicable diseases you have that may be detrimental to our staff or patients, please list:

**PART 2**

The PPD skin test is given to determine if you have developed an immune response to the bacterium that causes tuberculosis (TB). The AmeriCares Free Clinic facilities are considered low risk for TB protocols.

TB skin testing (TST) will follow CDC guidelines:

- If negative test within last twelve months – single TST required
- If two or more negative TST in the past – single TST required
- If no history of TST - the TST will be administered followed within 1-3 weeks by second TST (two step protocol)
- If single negative TST more than twelve months ago – two step protocol as above
- If TB skin test was positive (15 mm or more of in duration with no known risk factors), please complete positive section below.

**(over)**

Date of your last PPD \_\_\_\_\_ Result: Positive  Negative   
Date of prior negative PPD \_\_\_\_\_

PPD tests can be administered at the AmeriCares Free Clinic where you volunteer.

Clinic administered PPD: date \_\_\_\_\_ Result: \_\_\_\_\_ in mm  
(If 2-step) 2<sup>nd</sup> PPD: date \_\_\_\_\_ Result: \_\_\_\_\_ in mm

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### PART 3

Answer only if you have had a positive PPD test in the past.

Date of chest X-ray: \_\_\_\_\_ Result: \_\_\_\_\_

Based on chest X-ray results, was any preventative treatment advised? \_\_\_\_\_

If preventive treatment was advised, was it completed? Yes  No  (if not please explain below)

#### In the last year . . .

- |   |     |    |
|---|-----|----|
| • Have you had a productive cough?      | YES | NO |
| • Has it lasted $\geq 3$ weeks          | YES | NO |
| • Have you coughed up blood?            | YES | NO |
| • Have you had fevers?                  | YES | NO |
| • Have you had night sweats?            | YES | NO |
| • Have you had unexplained weight loss? | YES | NO |
| • Have you had weakness or fatigue?     | YES | NO |

If you answered YES to any of the above questions please define onset and duration of symptoms below.

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I understand this process is intended to protect the patients and staff of the AmeriCares Free Clinics. Any and all information herein will be kept confidential and not be made available to any other party. A copy will be provided to me at my request.

Printed name: \_\_\_\_\_ Clinic: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

1/2012