Children's Mercy Occupational Health
Student / Observer Health Form

Please Print ALL Entries

Name (Last) (First) (Middle Initial)			**Gender** Male Female	**Today's Date**
Address (Street, City, State, Zip Code)		**Personal Phone**		**Date of Birth**
School of Affiliation	**First day of experience at CM**	**Specialty / Role / Dept.**		**CM Instructor or Contact**

Required Immunization History and/or Test Results

- You must **attach copies of your immunization records** AND complete the following:

Needed for Compliance:	**Vaccine Dates:**		**Lab Results:**	**Need:**
MMR (Measles/Mumps/Rubella) Immunity	MMR #1: ____/____/____ MMR #2: ____/____/____	Or	Rubeola Titer: ____/____/____ Result: _____ Mumps Titer: ____/____/____ Result: _____ Rubella Titer: ____/____/____ Result: _____	☐
Varicella (Chicken Pox) Immunity	Varicella #1: ____/____/____ Varicella #2: ____/____/____	Or	Varicella Titer: ____/____/____ Result: _____	☐
Tdap (Tetanus/Diptheria/Pertussis) Vaccine	Date: ____/____/____			☐
Influenza Vaccine *(Required only during current flu season)*	Date: ____/____/____			☐
COVID -19 Vaccine	Date: ____/____/_____ Date: ____/____/_____ Date: ____/____/_____		Manufacturer: _____	
Tuberculosis (TB) Screening	Provide documentation of a negative TB screening; either IGRA blood test (T-spot or QFT) or TB skin test (TST), completed within the 12 months prior to arrival at CM. Any positive TB screenings must include documentation of the positive test and/or treatment for latent tuberculosis and a negative chest x-ray report within the past 6 months. In addition, the student must complete a TB Symptom Screen questionnaire indicating no signs of active tuberculosis.			☐
	TST 1: ___/___/___ Result: _____ TST 2: ___/___/___ Result: _____	Or	TB blood assay: ___/___/___ Result: _____	
	Chest X-Ray following a positive TB screening: ___/___/___ X-ray Result: _____			
Hepatitis B Vaccine *(Not required; recommended if risk of exposure to blood or body fluids)*	HepB #1: ____/____/____ HepB #2: ____/____/____ HepB #3: ____/____/____	and	HepB Titer: ____/____/____ Result: _____	☐

I hereby declare that the information provided on this form is true and complete. I understand that false information or omissions could cause me to be subject to loss of student / observer privileges.

_____ _____
Student / Observer Signature Date

☐ Compliant with CM requirements per Occupational Health review

☐ **NON-COMPLIANT with CM requirements** as follows: _____

_____

_____ _____
Occupational Health Representative Date