

# UWMC - Employee Health Center

## IMMUNIZATION HEALTH HISTORY CHECKLIST

As a UW Medicine health care worker, it is necessary that you comply with UW Medicine policy and OSHA guidelines regarding immunizations and TB testing prior to starting your residency/fellowship appointment.

Following is the list of documentation of immunization and/or documents of positive serology that must be submitted to UWMC–Employee Health Center by **May 7, 2010**. If you are starting later in the academic year, your paperwork must be submitted **no later than one month** before your appointment start date. You may submit your documentation via:

**Fax:** (206) 598-4469,

**Email:** [fogusl@u.washington.edu](mailto:fogusl@u.washington.edu), OR

**Mail** in the pre-addressed/pre-paid envelope provided to you by your program. If you did not receive an envelope, please mail to:

University of Washington Medical Center-Employee Health Center

Attention: GME Immunization Program

Box 356122

University of Washington

Seattle, WA 98105-9950

### Required documentation:

- Completed Adult Immunization Health History and Consent Form
- Measles** –
  - If born before 1/1/1957: Need proof of 1 dose live vaccine given after 12 months of age, OR (+) Serology
  - If born after 1/1/1957: Need proof of 2 doses of live vaccine given after 12 months of age and at least one month apart (given as MMR or measles only vaccine), OR (+) Serology
- Mumps** –
  - If born before 1/1/1957: Need proof of 1 dose live vaccine given after 12 months of age, OR Physician documented disease history, OR (+) Serology
  - If born after 1/1/1957: Need proof of 2 doses live vaccine given after 12 months of age and at least one month apart, OR Physician documented disease history, OR (+) Serology
- Rubella** – (+) Serology/or 1 dose MMR vaccine / or monovalent antigen rubella vaccine
- Hepatitis B** – Completion of the 3 dose vaccine series **AND** positive HbsAb serology (Campus Health waiver required if you elect not to have series)
- Varicella** – (+) Serology/ disease history/ or proof of 2 doses of varicella vaccine
- Tdap** – Documentation of 1 dose within the last 10 years
- TB** –
  - Screening results for personnel with **prior non-reactive skin tests** within the last 12 months (after June 2006), OR
  - Personnel with a **prior positive PPD**, must provide written documentation of PPD as well as a chest x-ray report that was completed within the last 12 months (you will be asked to complete a TB symptom survey upon your arrival to UWMC-Campus Health Center). History of BCG vaccination without documentation of a positive PPD does not exempt residents/fellows from skin testing.

Before your appointment start date, you will need to receive your baseline TB skin test and immunization clearance. This may be done at your program orientation; by stopping by UWMC – EHC (open Monday – Friday from 7:30 a.m. – 12:00 noon and 1 p.m. – 4 p.m. in room NE 210 on the 2<sup>nd</sup> floor of UWMC); or by sending completed TB readings from another location to UWMC-EHC.

If you have any questions, please contact UWMC-EHC @ (206) 598-7468 or (206) 598-4848.

## IMMUNIZATION HEALTH HISTORY

Name (Last, First)	SSN
DOB	RESIDENT/FELLOW (please circle)
Home Address (Street, City, State, Zip)	
Home Telephone	Work Telephone
UW Program Name and Box Number	E-Mail (must be current)
Interim Contact Name	Interim Contact Phone
Interim Contact E-Mail	Interim Contact Fax ((If available)

**PLEASE ANSWER ALL QUESTIONS BELOW:**

- YES     NO    Have you ever had a severe reaction to any vaccine? If yes, please describe: \_\_\_\_\_
- YES     NO    Are you allergic to eggs, baker's yeast, gelatin, streptomycin, neomycin, formaldehyde, merthiolate/thimerosal? (Please circle all that apply)
- YES     NO    Do you have any allergies? (Please list) \_\_\_\_\_
- YES     NO    Have you had a fever, diarrhea or vomiting today?
- YES     NO    Are you or is anyone in your household immune suppressed? (i.e. HIV/AIDS< organ transplant, etc)
- YES     NO    Are you receiving treatment for any chronic illness?
- YES     NO    Have you had Immune Globulin (Gamma Globulin) or received blood or blood products in the past seven months?
- YES     NO    Have you ever had Guillian-Barre Syndrome, a condition which causes paralysis?
- YES     NO    Are you pregnant or planning a pregnancy in the next month?

Are you allergic to fruits, vegetables or other foods?    (Please List)    \_\_\_\_\_

Are you allergic to latex products?    (Please Describe)    \_\_\_\_\_

Are you allergic to animals?    (Please List)    \_\_\_\_\_

Do you have a history of:    eczema or psoriasis    (Please Circle)

Please list all of the prescription or over the counter medications that you are now taking:

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PT. NO

NAME:

DOB:

**University of Washington Academic Medical Center**

Harborview Medical Center – UW Medical Center

University of Washington Physicians

Seattle, Washington

**ADULT IMMUNIZATION HEALTH HISTORY & CONSENT  
EMPLOYEE HEALTH SERVICE CLINIC**