Children's Mercy Occupational Health
Student / Observer Health Form

Please Print ALL Entries

Name (Last)	**(First)**	**(Middle Initial)**	**Gender**	**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/or lab results** AND complete the following:

Needed for Compliance:	**Dates:**		**Lab Results:**	**Needs:**
MMR (Measles/Mumps/Rubella) Immunity *(2 vaccines or titers that verify immunity)*	MMR #1: ____/____/____ MMR #2: ____/____/____	Or	Rubeola Titer: ____/____/___ Result: _____ Mumps Titer: ____/____/____ Result: _____ Rubella Titer: ____/____/____ Result: _____	☐
Varicella (Chicken Pox) Immunity *(2 vaccines or titers that verify immunity)*	Varicella #1: ____/____/____ Varicella #2: ____/____/____	Or	Varicella Titer: ____/____/____ Result: _____	☐
Tdap Vaccine (Tetanus/diphtheria/pertussis)	Date: _____/_____/_____			☐
Influenza Vaccine *(Required only during current flu season)*	Date: _____/_____/_____			☐
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:____/____/____Result:_____	Or	TB blood assay: ___/___/___ Result: _____	
	Chest X-Ray following a previous positive result: ___/___/___ Result: _____			
Hepatitis B Vaccine *(Not required; recommended if risk of exposure to blood or body fluids)*	HepB #1: _____/_____/_____ HepB #2: _____/_____/_____ HepB #3: _____/_____/_____		HepB Titer: ____/____/____ Result: _____	
COVID-19 Vaccine *(Not required; recommended)*	Dose #1: _____/_____/_____ Dose #2: _____/_____/_____ Manufacturer: _____		Additional Doses: ____/____/____ Manufacturer: _____ ____/____/____ Manufacturer: _____ ____/____/____ Manufacturer: _____	☐

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 affiliation privileges.

_____ _____

Student / Observer Signature Date

☐ Compliant with CM requirements per Occupational Health review

☐ NON-COMPLIANT with CM requirements for reasons stated:_____

_____

Occupational Health Representative _____ Date _____

Please direct questions to:
Children's Mercy Occupational Health
2401 Gillham Road | Kansas City, MO 64108
P: (816) 234-3179 | F: (816) 460-1077
occupationalhealth@cmh.edu