St. Christopher's Hospital for Children
A PARTNERSHIP OF TOWER HEALTH AND DREXEL UNIVERSITY

160 East Erie Avenue
Philadelphia, PA 19134-1095
Tel: (215) 427-5000

Dear Applicant:

Thank you for your interest in St. Christopher's Hospital for Children. Please review the information below that lists the prerequisites for participating in activities at the hospital. NOTE: All steps must be completed and required documentation received before you begin the requested activity.

1. Please access the appropriate application and information sheets by clicking on the links located on the volunteering page of the St. Christopher's website: https://towerhealth.org/locations/st-christophers-hospital-children/volunteering

2. Make note of the criteria and information required for your activity of interest.

3. Complete required steps and gather all required documentation.

4. Please send completed volunteer application forms to:
   Email: STCVolunteer@towerhealth.org (Please put your name and "Volunteer Application" in the subject line.)
   Mail: Volunteers Department St. Christopher's Hospital for Children 160 East Erie Avenue Philadelphia, PA 19134-1095

5. For questions or assistance with the application process, please contact Barbara A. Liccio, Director of Volunteer Services at (215) 427-5398.

When all of the required information and documentation has been submitted, a representative from Volunteer Services will contact you to discuss next steps.

Thank you for your interest.

St. Christopher's Hospital for Children
A PARTNERSHIP OF TOWER HEALTH AND DREXEL UNIVERSITY

VOLUNTEER ON-BOARDING PROCESS
INFORMATION SHEET

A volunteer is defined as anyone who provides a service without pay for personal gratification not required for academic purposes, contractual agreement or monetary gain.

On-boarding of volunteers will be handled by the Department of Volunteer Services. The point of contact for Volunteer Services is: Barbara A. Liccio, Director of Volunteer Services, 215-427-5398

Initiation of on-boarding process:

- Interested applicants who contact Volunteer Services Department expressing interest in volunteering will be directed to the St. Christopher's Hospital for Children's website for completion of application packet: http://www.stchristophershospital.com/volunteering

- Completed application packet is returned to Volunteer Services Department (Department Director and/or designee) for review of required documents. ***On-boarding may take 30-45 days to complete.***

    - Application
    - Consent documentation for "serving without pay" (minors, ages 15-17)
    - Application Agreement
    - Personal Statement of Intent
    - Skill Bank
    - Parental Release Form (minors, ages 15-17)
    - Authorization for Release of Medical Information
    - Tuberculin (TB) Test Consent Form
    - Pre-Volunteer Drug Testing Consent Form
    - St. Christopher's Hospital for Children has contracted with Sterling (a leading consumer reporting agency) to perform background investigation as part of the application process. You will need to complete an electronic consent and disclosure form that will be emailed to you on a later date. It is important for you to check your email regularly for on-going communication from Sterling regarding your background investigation.
    - Child Abuse History Clearance Information (Will be facilitated by volunteer candidate. For Child Abuse Clearance, free of charge, please go to: www.compass.state.pa.us/cwis/public/home

Required documents:

- Must provide current immunization records or documentation of having immunity for the following infectious diseases: Measles, Mumps, Rubella, Varicella (Chicken Pox), Hepatitis B, Tetanus, Diphtheria, proof of PPD (Tuberculosis) testing twice during the past twelve months or QuantiFERON and Influenza vaccine during the present Flu season (September through April) is also required. Documentation of immunity will expedite the process.

St. Christopher's Hospital for Children
A PARTNERSHIP OF TOWER HEALTH AND DREXEL UNIVERSITY

VOLUNTEER ON-BOARDING PROCESS INFORMATION SHEET

- Child Abuse History Clearance must be obtained within the past six months. St. Christopher's Hospital for Children will conduct screenings for FBI IdentoGo Fingerprinting Clearance and Criminal Background checks.
- Complete Reference Forms: 1 personal and 1 professional

Students (minors, ages 15-17):

- Consent documentation for "serving without pay"
- Parental Release Form
- Letter of Reference from School for student applicants
- Completed application packet should be returned to Volunteer Services Department for in-processing and on-boarding process. Volunteer Services will evaluate the completion of the submitted application packet. Volunteer applicant will be notified by staff member of Volunteer Services Department if there are any files with missing documentation.
- Volunteer Services will schedule an interview with applicant
- Volunteer Services will work with departments in the development of the volunteer service descriptions for assigned volunteers
- Volunteer Services approved applicants will then be scheduled by Volunteer staff for appointment with Employee Health for drug screening and physical
- Volunteer Services will schedule volunteer applicant for hospital orientation
- Volunteer services will communicate with volunteer applicant days, hours and start date
- Volunteer Services will provide document for issuing hospital I.D. badge (Hospital Security will not accept any I.D. badge request form for volunteers without the prior consent of the Department of Volunteer Services via a formally signed document).

VOLUNTEER ON-BOARDING PROCESS
INFORMATION SHEET

<u>Termination Process</u>:

- Volunteer Services Director or designee will collect hospital I.D. badge from volunteer on their last day and maintain in archive file.
- Volunteer Services Director or designee will notify security of termination of volunteer status.
- Volunteer Services Director or designee will notify Human Resources of termination of volunteer who has had computer or system access and will follow the employment termination process.

St. Christopher's Hospital for Children
A PARTNERSHIP OF TOWER HEALTH AND DREXEL UNIVERSITY

VOLUNTEER APPLICANT

Categories Include:
Adult Volunteer
Student Volunteer
Pet Therapy Volunteer
Shadowing

Summary of Necessary Application Steps:

Complete application packet

Provide Department of Public Welfare Pennsylvania Child Abuse History Clearance within the past six months. St. Christopher's Hospital for Children has contracted with Sterling (a leading consumer reporting agency) to perform background investigation as part of the application process. You will need to complete an electronic consent and disclosure form that will be emailed to you on a later date. It is important for you to check your email regularly for on-going communication from Sterling regarding your background investigation.

Provide current immunization records or documentation of having immunity for the following infectious diseases: Measles, Mumps, Rubella, Varicella (Chicken Pox), Hepatitis B, Tetanus, Diphtheria. Proof of PPD (Tuberculosis) testing twice during the past twelve months and Influenza Vaccine during the present Flu season (September through April) is also required. Documentation of immunity will expedite the process.

Agree to be screened by St. Christopher's Hospital for Children Employee Health Services. Screening to include: Physical, Drug Screening, QuantiFERON and Influenza vaccine. If applicant can provide documentation of QuantiFERON Employee Health Services will review results for clearance.

Provide 2 references

Attend Hospital Volunteer Orientation

For additional information please contact:

Barbara A. Liccio, Director of Volunteer Services at (215) 427-5398.

VOLUNTEER APPLICATION PACKET

Volunteer Services
160 East Erie Avenue
Philadelphia, PA 19134-1095
(215) 427-5398

We take pride in the diversity provided in our workplace and provide equal employment opportunity for all qualified applicants.

St. Christopher's Hospital for Children is a tobacco-free workplace.

Please note this application does not apply to Shadowers. Individuals interested in Shadowing should refer to the Shadowing Application.

Please Check one:
☐ Adult
☐ Student (minor, age 15-17)
☐ Pet Therapy

Date Received: ___________
Application:_____ **Complete**____ **Incomplete**
Date Interviewed: ___________

VOLUNTEER APPLICATION

PLEASE PRINT

Date: __________________ Date of Birth: _________________

Name: ____
(Last) (First) (Middle)

Present Address: ____
(Street) (City) (State) (Zip)

Telephone: Home ( ) ____________________ Work ( ) ____________________

E-mail address: ____________________ Cell ( ) ____________________

If minor, Name of Parent or Guardian ____

IN CASE OF EMERGENCY, NOTIFY:

____
Name Address City, State, Zip

____
Relationship Telephone Number Cell Phone Number

____
Email address

SERVICE AREA AND TIME PREFERENCE:

☐ Monday ☐ Tuesday ☐ Wednesday ☐ Thursday ☐ Friday ☐ Saturday ☐ Sunday

Hrs: Hrs: Hrs:______ Hrs:______ Hrs:_____ Hrs: Hrs:_____

When do you prefer to volunteer? (Check all that apply): Morning Afternoon Evening

Please specify preference:

No patient contact Limited patient contact Clerical

Patient contact | Children’s Services | Pet Therapy

Are there any work activities or conditions that you must avoid? Yes ☐ No ☐ Please list: ____________________

Is there any reason you will not be able to carry out in a safe manner all assignments associated with this role?
Yes ☐ No ☐

VOLUNTEER APPLICATION

EDUCATION:

Education (Please Circle) Grades 1 2 3 4 6 7 8 9 10 11 12 College Degrees Obtained or In Progress:

____

School presently attending:____

Education program or special training (describe):

____

If minor, please provide name of school____________________________Grade __________

EMPLOYMENT/VOLUNTEER HISTORY: Starting with your most recent, list all positions and activities including self-employment, volunteer work, and all significant experience.

Employer	Street City State Zip Code
Job Title	Supervisor Name & Telephone Number
Date Employed (mo/yr)	Date separated (mo/yr)
Duties	
Reason for leaving	

Employer	Street City State Zip Code
Job Title	Supervisor Name & Telephone Number
Date Employed (mo/yr)	Date separated (mo/yr)

Duties
Reason for leaving

Employed___________ **Unemployed**____________ **Retired**____________

St. Christopher's Hospital for Children
A PARTNERSHIP OF TOWER HEALTH AND DREXEL UNIVERSITY

VOLUNTEER APPLICATION

PERSONAL REFERENCE (Other than relatives) – Please provide full mailing address.

NAME	STREET/CITY/STATE/ZIP	PHONE
		Home: Work: E-mail:
		Home: Work: E-mail:

PET THERAPY PROGRAM VOLUNTEERS

PET INFORMATION:

Name of Dog: ________________________ Date of Birth: ____________

Dog Breed: ________________________ Gender: ☐ Male ☐ Female

PET CERTIFICATION:

Has dog been certified? Yes ☐ No ☐ Date of Certification: ____________________

Certifying Agency (please check appropriate box): Pet Partners ☐ ☐ Therapy Dog International

☐ Other ____

Has dog been a part of a Pet Therapy Program Previously? Yes ☐ No ☐

If yes, please provide information to include, Agency/Hospital name, contact information and length of involvement

Name of Agency: ____________________ Contact Person: ____________________

Phone #: ____________________ Email Address: ____________________

Length of Involvement: ______________ Start Date: __________ End Date: __________

IF USING A HARD COPY OF THIS APPLICATION, PLEASE RETURN TO:

ST. CHRISTOPHER'S HOSPITAL FOR CHILDREN
DEPARTMENT OF VOLUNTEER SERVICES 160
EAST ERIE AVENUE
PHILADELPHIA, PA 19134-1095

St. Christopher's Hospital for Children
A PARTNERSHIP OF TOWER HEALTH AND DREXEL UNIVERSITY

Student Volunteer
(minors, ages 15-17)

Student volunteers minors, ages 15-17 must complete this application him or herself. All volunteers serve without pay. Students must show proof of age, photo identification and immunization records. Parental permission is required.

Print Name _______________ Date

Signature of Student _______________ Date

Consent for minors ages 15-17 (to be completed by parent or person responsible)

I hereby give my consent for _______________ to serve as a volunteer at St. Christopher's Hospital for Children.

Print Name _______________ Date

Signature of Parent or Guardian _______________ Date

St. Christopher's Hospital for Children
A PARTNERSHIP OF TOWER HEALTH AND DREXEL UNIVERSITY

VOLUNTEER APPLICATION

APPLICANT AGREEMENT:

- I certify that the information contained in this application is correct and complete to the best of my knowledge.

- Acceptance as a Traditional Volunteer at St. Christopher's Hospital for Children is contingent upon satisfactory completion of all pre-placement procedures which includes, but is not limited to, an interview, verification of references, criminal background, FBI IdentoGo Fingerprinting, Child Abuse investigation, drug screening, orientation, health screening, tuberculosis screening, and Flu shot.

- I realize that misrepresentation of facts will be cause for rejection of this application. In the event of placement in the volunteer program, falsification of any information on this application will be cause for dismissal.

- I authorize St. Christopher's Hospital for Children to investigate the information provided on this application and to conduct a Drug Screening, Criminal Background Investigation, Child Abuse investigation, and FBI IdentoGOFingerprinting. I will hold no person liable for giving or receiving information with regard to these investigations.

- I agree to abide by the policies of St. Christopher's Hospital for Children and the Standards of Conduct which will be discussed and distributed during hospital volunteer orientation.

- I authorize St. Christopher's Hospital for Children to use photographs of me taken at hospital for marketing, public relations, recruitment, and/or educational purposes, and waive any rights to compensation for these uses. The term photograph shall mean modern pictures or still photography in any format and as well as videotape, video disc, digital, electronic, or other mechanical means of recording and reproducing images.

- I, ___________________________________, understand and acknowledge that, upon both my successful completion of the volunteer placement process required by St. Christopher's Hospital for Children and the receipt of approval for service by Volunteer Services management, I will become a "volunteer". As a volunteer, I acknowledge that I will not receive compensation for services. I acknowledge that I will receive a volunteer service description to specify the department(s) that I will be volunteering in prior to my placement(s). A signed copy of that (those) volunteer service description(s) will be in my volunteer file.

____

PRINT NAME **DATE**

____

SIGNATURE OF APPLICANT **DATE**

____

SIGNATURE OF VOLUNTEER SERVICES DIRECTOR **DATE**

VOLUNTEER APPLICATION

PERSONAL STATEMENT OF INTENT

1. Why did you select St. Christopher's Hospital for Children for your volunteer work?

____

____

____

2. What would you like to gain from this experience?

____

____

____

3. In what way will St. Christopher's Hospital for Children benefit from your volunteering?

____

____

____

4. Describe any special skills and languages that you feel will be helpful as a volunteer:

____

____

____

5. What area would you like to volunteer in? Why?

____

____

____

6. Are there any special considerations that you would like us to keep in mind when reviewing your volunteer application?

____

____

____

St. Christopher's Hospital for Children
A PARTNERSHIP OF TOWER HEALTH AND DREXEL UNIVERSITY

VOLUNTEER APPLICATION

SKILLBANK (Please check all that apply)

BUSINESS PROFESSIONALS

- CERTIFIED PUBLIC ACCOUNTANT
- CUSTOMER SERVICE
- HUMAN RESOURCES SPECIALIST
- RETAIL SALES
- LAWYER
- OTHER____

SKILLED TRADES

- HAIR STYLIST
- LANDSCAPING
- MAKEUP ARTIST
- MANICURIST
- MAINTENANCE

ARTS AND ENTERTAINMENT

- ACTING
- BALLOON ART
- BAND
- FACE PAINTING
- JUGGLING
- MUSIC INSTRUMENT TYPE: ____________________________
- SINGING
- STORY TELLER
- OTHER:____

ADMINISTRATIVE SUPPORT

- COMPUTER PROGRAMS (ACCESS, EXCEL, POWER POINT, AND WORD)
  SPECIFY TYPES:____
- DATA ENTRY
- FILING
- GENERAL OFFICE ASSISTANCE
- MAILING

COMMUNICATION

- CALLIGRAPHY
- FOREIGN LANGUAGE:________________________
- GRAPHIC DESIGN
- MARKETING/PROMOTION
- MULTIMEDIA PRODUCTION
- NEWSLETTER/BROCHURE
- PUBLISHING
- PHOTOGRAPHY
- PUBLIC RELATIONS
- SIGN LANGUAGE
- TOUR GUIDES
- VIDEO PRODUCTION
- WRITING
- OTHER:_____________________________________

EDUCATION

- DAY CARE AIDE
- ELEMENTARY SCHOOL TEACHER
- EXC INSTRUCTOR
- HIGH SCHOOL TUTOR
- GED INSTRUCTOR
- LIBRARIAN
- LIFE SKILLS INSTRUCTOR
- LITERACY INSTRUCTOR
- MIDDLE SCHOOL TEACHER
- SPECIAL EDUCATION
- OTHER:_____________________________________

NON-PROFIT ADMINISTRATION

- FUNDRAISING
- GRANT WRITING
- SPECIAL EVENT PLANNING
- VOLUNTEER RECRUITMENT AND TRAINING

RECEPTIONIST

TELEMARKETING

OTHER:____

HEALTH AND MEDICAL SERVICES

NURSE

NUTRITIONIST

PHYSICAL THERAPY

PHYSICIAN TYPE:_____________________________________

OTHER :____

NATURAL RESOURCES

ENVIRONMENTAL EDUCATION

GARDENING / HORTICULTURE

LANDSCAPE ARCHITECT

RECYCLING

OTHER: ____

GENERAL ASSISTANCE

TELEPHONE

TRANSPORTATION/DRIVER

OTHER: ____

OTHER:_____________________________________
_

HAND CRAFT SKILLS

ARTS AND CRAFTS

CERAMICS/POTTERY

NEEDLE CRAFT

WOOD WORKING

OTHER:_____________________________________
_

CORPORATE TRAINING

CULTURAL SENSITIVITY

CUSTOMER SERVICE

FACILITATE

LEADERSHIP DEVELOPMENT

MANAGEMENT SKILLS

MOTIVATIONAL

STRESS MANAGEMENT

TEAM BUILDING

TIME MANAGEMENT

OTHER:_____________________________________
__

St. Christopher's Hospital for Children
A PARTNERSHIP OF TOWER HEALTH AND DREXEL UNIVERSITY

Student Volunteer
(minors, ages 15-17)

PARENTAL RELEASE FORM

Parents of Prospective Student Volunteers (minor)

St. Christopher's Hospital for Children, a for-profit, nonsectarian medical center, treats thousands of children each year. Because we specialize in the care of children, it is important that those who assist staff in the delivery of care are of the highest quality. For this reason, we are requesting that the school which your child attends supply a "Letter of Reference," which is designed to assist in the screening process. We will take both the character of the individual and academic standing into consideration.

Please sign the form below giving your child's guidance counselor permission to supply us with the letter of reference. If you have any questions, please feel free to contact me at (215) 427-5398. Your assistance and cooperation is greatly appreciated.

- I hereby give my consent for a "Letter of Reference" to be sent to St. Christopher's Hospital for Children.

____
Print Name

____
Parents' Signature

____
Date

____
Child's Name

____
Name of School and Grade

St. Christopher's Hospital for Children
A PARTNERSHIP OF TOWER HEALTH AND DREXEL UNIVERSITY

Student Volunteer
(minors, ages 15-17)

LETTER OF REFERENCE

________________________________, a student at your school is interested in becoming a volunteer at St. Christopher's Hospital for Children. The form below represents a minimal record of your student's abilities. After filling in the rating scale, please feel free to make additional comments.

Please be prompt in returning this letter of reference as the student's application will not be processed until we have received this information from you.

Your cooperation is greatly appreciated. If you have any questions, please feel free to contact the Volunteer Services Department at 215- 427-5398.

____
(Print Student's Name)

	Superior	Above Average	Average	Below Average	Poor	Don't know
Student attendance						
Quality of academic work						
Ability to work with peers						
Ability to work with faculty						
Dependability						
Leadership qualities						
Resourcefulness						
General effectiveness						

Additional Comments:

____

____

____
Counselor's Name

____
Date

____
Counselor's Signature

____
School

St. Christopher's
Hospital for Children
A PARTNERSHIP OF TOWER HEALTH
AND DREXEL UNIVERSITY

_____ Phone number

St. Christopher's Hospital for Children
A PARTNERSHIP OF TOWER HEALTH AND DREXEL UNIVERSITY

VOLUNTEER APPLICATION

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Please complete this form and return it, along with your application to the Volunteer Services Department. We must have this completed form in order to process your application.

I hereby authorize this office to release immunization records to St. Christopher's Hospital for Children. I understand that I may cancel this authorization at any time except when the above information has already been released in accordance with this authorization. This authorization is void within sixty (60) days from the date of signature. Further, I certify that I understand the nature of this release.

Print Name ______________________________ Date ____________________

Signature ______________________________ Date of Birth ____________________

Parent/Legal Guardian Signature ______________________________
(Required if age 15 to 17)

TO BE COMPLETED BY MEDICAL CARE PROVIDER

Immunization History – Please attach immunization records indicating proof and date of immunizations for the infectious diseases listed below. If over age 18, proof of titers must be provided.

Measles (Rubeola)	Rubel la	Varicella (Chicken Pox)	Hepatitis B
Immunity required	Immunity required	Immunity required	Immunity required
2 Vaccine doses (dates)	2 Vaccine doses (dates)	2 Vaccines (dates)	3 Vaccines doses (dates)
or	or	or	or
Titer results (date required)	Titer results (date required)	Titer results (date required)	Titer results (date required)

Mumps	Tdap (Tetanus-Diphtheria)	Flu Shot
Immunity required	Proof of Tdap is required	During Flu Season
2 Vaccine doses (dates)	(date)	(September through April)
or	Within past 10 years	(date)
Titer results (date required)		

Tuberculosis History

Most recent TB skin test (2PPD's) Date ____________ Result ____________mm induration

If PPD result – 10 mm induration	CXR Date _________	Result ______________
History of Tuberculosis Disease?	Yes _______________	No _________________
Treatment of TB infection or Disease?	Medication _______	Dates ____________ to ____________

Must have letter regarding treatment

____
Medical Care Provider's Signature

Provider's Office Stamp with Address

St. Christopher's Hospital for Children
A PARTNERSHIP OF TOWER HEALTH AND DREXEL UNIVERSITY

VOLUNTEER APPLICATION

EMPLOYEE HEALTH SCREENING

I give permission for St. Christopher's Hospital for Children to administer a QuantiFERON Blood test for tuberculin screening:

If applicant can provide documentation of 2 PPD's within the past 12 months QuantiFERON will not be required.

- My child ____
  (Print Name)
- Myself ____
  (Print Name)

____ ________________________
Signature of Volunteer Date

____ ________________________
Signature of Parent/Guardian Date

****

I give permission for St. Christopher's Hospital for Children to administer a Flu shot during Flu season (September through April)

If applicant can provide documentation of Flu shot being administered during the time period of September through April of present year, a Flu shot will not be required.

- My child ____
  (Print Name)
- Myself ____
  (Print Name)

____ ________________________
Signature of Volunteer Date

____ ________________________
Signature of Parent/Guardian Date

St. Christopher's Hospital for Children
A PARTNERSHIP OF TOWER HEALTH AND DREXEL UNIVERSITY

VOLUNTEER APPLICATION

EMPLOYEE HEALTH SCREENING

Please bring with you a recent photo I.D. and SS# for in-processing of drug screening.

PRE-VOLUNTEER DRUG TESTING CONSENT FORM

I consent freely and voluntarily to the testing of (my/my child's) urine specimen for the presence of illegal or unauthorized drugs. I hereby release and hold harmless American Academic Health System and its agents from any liability arising as a result of this testing. I further understand that passing the pre-volunteering drug test is a requirement for volunteering.

____
Volunteer Name (Please Print)

____
Volunteer Telephone Number

____
Volunteer Signature Date

____
Parent Signature Date

****

To be signed day of drug screening by applicant:

I certify that this urine sample was provided by me, was not altered, and was placed in a container, sealed and labeled in my presence.

____
Volunteer Name (Please Print)

____
Volunteer Signature Date

****THIS CLEARANCE WILL BE MAILED TO THE ADDRESS THAT YOU LIST BELOW. PLEASE BE SURE TO WRITE YOUR ADDRESS DOWN CORRECTLY AND BRING COMPLETED FORM TO THE VOLUNTEER SERVICES DEPARTMENT.**

St. Christopher's Hospital for Children
A PARTNERSHIP OF TOWER HEALTH AND DREXEL UNIVERSITY

Healthcare Worker Annual Symptom, Exposure, and Risk Assessment Questionnaire

Print NAME (Last)	(First)	(M.I.)	DATE OF BIRTH month_________ day_________ year____
Department/ Unit / Clinic			Contact phone number:

Signs & Symptoms of Tuberculosis

▫ Yes ▫ No Have you lost unexplainable weight in the last 6 months without dieting? If yes, how much? ____________
▫ Yes ▫ No Do you on a regular basis have unexplainable night sweats or wake up with the sheets wet from sweating? If yes, how long ______________________________
▫ Yes ▫ No Do you have a frequent persistent cough? If yes, how long? ____
▫ Yes ▫ No Do you feel tired all the time? If yes, how long? ____
▫ Yes ▫ No Do you have shortness of breath or chest pain? If yes, how long? ________________________________
▫ Yes ▫ No Do you cough up blood? If yes, how long? ____
▫ Yes ▫ No Have you been having fevers? If yes, how long? __________________________________

If yes, to any of the above refer patient to Employee Health immediately and provide an N95 mask if coughing

Tuberculosis Risk Factors

▫ Yes ▫ No Were you born in the U.S.?
▫ Yes ▫ No Have you traveled or lived outside the U.S. in the last 5 years
▫ Yes ▫ No Have you held temporary or permanent residence (≥ 1 month) OR delivered medical care in a country with a high TB rate in the last 5 years (i.e. any country other than Australia, Canada, New Zealand, the United States, and those in northern or Western Europe).
▫ Yes ▫ No Since your last TB test, have you had close contact with someone who has had infectious TB disease?
▫ Yes ▫ No Do you have any current condition that may cause you to be immunocompromised? For example, HIV infection, organ transplant recipient, prolonged treatment with steroids (≥ 15 mg/day of prednisone for ≥ 1 month), other immunosuppressive medications such as tumor necrosis factor-alpha antagonist (infliximab, etanercept, or others)
▫ Yes ▫ No Since your last TB test, have you lived, worked or volunteered in a homeless shelter, correctional facility, long term care facility or a refugee camp

Medical History

▫ Yes ▫ No Have you ever had a positive TB skin test or blood test?
If yes, Date of last positive TB skin or blood test: ___________ Was it a PPD or blood test? ________
Did you have a chest x-ray at the time? Date ____________
▫ Yes ▫ No Have you ever had TB infection? If yes, year __________ Treated with medication? _______ If yes, date:_____
▫ Yes ▫ No Have you ever had TB disease (active TB)? If yes, year _____ Treated with medication? ______ date:_________
▫ Yes ▫ No Have you ever experienced a severe reaction (local or systemic) to a tuberculin skin test ?

I understand if I should experience any of the signs & symptoms of tuberculosis stated above at any time during the year, I will contact Employee Health and my Director immediately and not come to work until cleared by EH.

YES _____ No ______ Provided St. Christopher's Hospital Employee Health with documentation of my past positive PPD or TB blood test, TB diagnosis or severe allergy to TST.

Signature: ____ Date: ____________________________

Healthcare Worker Annual Symptom, Exposure, and Risk Assessment Questionnaire

*************************************Test Administrator Use Only*************************************

Employee Name ______________________________ DOB ____________________

☐ **Pre-employment** ☐ **Annual** ☐ **Post Exposure** ☐ **Other_______**

Screen reviewed by: ___________________________________ Credentials: _____________
Date: _______

Documentation of prior positive TB test or treatment on file ☐ No ☐ Yes,

Date of treatment if applicable________

Current Chest X-ray on file in EH ☐ Yes, result & date _________________

☐ **No, Refer the patient to Employee Health**

Comments:

HCW cleared for work by: ______________________________________ Credentials ________

Date: ______

St. Christopher's Hospital for Children
A PARTNERSHIP OF TOWER HEALTH AND DREXEL UNIVERSITY

OFFICE USE ONLY

Visit Type: LOG # ____________

___ New Hire ___ Volunteers Appt. Time: _______
___ RTW ___ Vaccine only
___ Students ___ Misc. Visit

****

EMPLOYEE HEALTH SERVICE DEPARTMENT
INTAKE & CONSENT FORM

Please Print Clearly

Today's Date: _____ / _____ / _____ Department: ___________________ Role: ____________ Start Date:_______

First Name: ___________________________ MI: _____ Last Name: ________________________________

Address: ____ Apt. # __________

City: ____ State: ____________ Zip Code: _____________

Home Phone #: ( ) _________________ Cell #: ( )______________ Email: ____________________________________

Date of Birth: _____ / _____ / _____ Gender: ___Male ___ Female

By signing below, I accept the following:

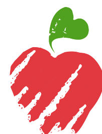
1. I consent to St. Christopher's Hospital for Children Employee Health Service Department (SCHCEH) to preforming work related exams and treatment. These may include vaccinations; care for a work related injury or illness, and / or work related physical exam.
2. I understand that work-related physical exams are not replacement for routine health care from my doctor. I also understand that a work related exam is not a complete evaluation. It is being done only to assess my ability to safely perform that tasks needed by the job I am applying for, or the job I currently hold.
3. I understand drug testing is a part of my pre-employment exam.
4. I consent to the release of all results of my pre-employment exam, including drug test results, to Human Resources.

Minor employees, volunteers, and students must have their parents and or legal guardian complete the below:

5. ____I GIVE CONSENT by my signature for my minor child to receive the influenza vaccine. (If this consent form is not signed, Influenza vaccine will not be given.)
6. _____I DO NOT GIVE CONSENT to receive the vaccine.
7. If you do not consent, an Exemption Form must be completed and submitted to EH for review and approval.
8. _____I DO NOT GIVE CONSENT for my child to be vaccinated with the influenza vaccine.
9. If you do not consent for your child to receive the influenza vaccine an Exemption Form must be completed and submitted to Employee Health for review and approval.

Print Patient's Name: ______________________ Patient Signature: ______________________ Date: _____ / _____ / _____

Print PARENTS Name: _____________________ ***PARENTS Signature:*** _____________________ Date: _____ / _____ / _____



St. Christopher's Hospital for Children
A PARTNERSHIP OF TOWER HEALTH AND DREXEL UNIVERSITY

Annual Influenza Vaccine Consent Form

Section 1: Information to Receive Vaccine (please print)

NAME (Last) PRINT	(First) PRINT	(M.I.)	DATE OF BIRTH month day year
LAST DIGITS OF YOUR SS #	AGE		
Department			Unit/ Clinic
Name of your Department Director, Manager, or Supervisor			
Employee of St Christopher's Hospital Yes______NO ______			
Are you a St. Christopher's Contracted Employee Yes___NO______Department ______________________			

Section 2: Screening for Vaccine Eligibility

The following questions will help us to know if you can get the seasonal influenza vaccine. If you answer "NO" to all four of the following questions, you can probably get the influenza vaccine. If you answer "YES" to one or more of the following four questions, you may be able to get the seasonal influenza vaccine, but we will discuss your options.
Please mark YES or NO for each question.

	YES	NO
1. Did you ever had a life-threatening allergic reaction after a dose of flu vaccine, or have a severe allergy to any part of this vaccine. **If yes, explain:**	☐	☐
2. Have you ever had Guillain-Barre Syndrome (a type of temporary severe muscle weakness) within 6 weeks after receiving a flu vaccine?	☐	☐

Section 3: Consent

CONSENT FOR VACCINATION:
I have been given and read the Current Influenza Vaccine Information Statement for the seasonal influenza vaccine and understand the risks and benefits.

________**I GIVE CONSENT** to St Christopher's Hospital to be vaccinated with the influenza vaccine. (If this consent form is not signed, then so not vaccinate)

________**I DO NOT GIVE CONSENT** to receive the vaccine.

Minor employees, volunteers, and students must have their parents and or lega1 guardian complete the below:

1. _____I GIVE CONSENT by my signature for my minor child to receive the influenza vaccine. (If this consent form is not signed, Influenza vaccine will not be given.)
2. _____I DO NOT GIVE CONSENT to receive the vaccine.
3. If you do not consent, an Exemption Form must be completed and submitted to EH for review and approval.
4. _____________I DO NOT GIVE CONSENT for my child to be vaccinated with the influenza vaccine.
5. If you do not consent for your child to receive the influenza vaccine an Exemption Form must be completed and submitted to Employee Health for review and approval.

Print Patient's Name:____________ ______Patient Signature:___________ Date: / /

Print *PARENTS Name:*____________ ***PARENTS Signature***:__________________Date:______/______/ _____

If you do not consent, an Exemption Form must be completed and submitted to EH for review and approval.

Signature____ **Date:** _________

Section 5: Vaccination Record

FOR ADMINISTRA TIVE HSE ONL Y

Vaccine	Route	Date Dose Administered	Vaccine Manufacturer	Lot Number	Name and Title of Vaccine Administrator
	☐ IM	/ /			