# EMPLOYEE HEALTH - REQUIREMENTS PACKET

**SUBMISSION DEADLINE: April 14, 2023**

# MEDICAL REQUIREMENTS - STUDENT SUMMER PROGRAMS

**SUBMISSION DEADLINE: April 14, 2023**

Dear Student,

We are delighted you have decided to join us at Cincinnati Children's this summer! Please carefully review the medical requirements and record submission instructions enclosed in this packet.

This packet includes information on the medical requirements all employees must complete prior to their start date (see next page for list). The 'Medical Requirements Form' found on page 5 & 6 must be completed by a healthcare provider and emailed to EH.Clinic@cchmc.org, unless official medical records are alternatively provided that meet the documentation requirements listed below (ex: immunization records found on MyChart). **Documentation of the medical requirements outlined in this packet must be sent via email and received by Employee Health no later than April 14, 2023.**

**Medical Record Submission Instructions:**

- Send medical records via email to Employee Health at EH.Clinic@cchmc.org
- Subject Line to Include: "Your Name" Medical Records & "Name of Summer Program"
- Attach the completed 'Medical Requirements Form' found on page 5 & 6 of this packet that was completed by your healthcare provider plus any other supplemental documentation (EX: TB test results) ***OR*** attach a copy of your official medical records from your healthcare provider containing the medical requirements outlined in this packet and adheres to our documentation submission requirements listed below.

**Documentation Submission Requirements** - *Records submitted must include the following details*:

- Patient Name and Date of Birth
- Healthcare Provider or Facility Name
- Name of vaccine administered and its dosage or positive IGg titer
- Date vaccine was administered
- Vaccine Brand name/manufacturer
- Covid vaccines must include manufacturer name
- Include documentation of TB and/or Titer test results

***Screenshots are not accepted if above requirements are not included***

**Resubmission will be requested and required for any medical records received that do not meet the documentation requirements outlined in this packet**

***MyChart Record Tip:*** *Click the Printer Icon to have the record generated with full patient details displayed.*

***Additional Health Requirements:***

- ***Urine Drug Test*** *- conducted by Employee Health during your pre-employment processing visit. Documentation of drug tests conducted by another facility will not be accepted in lieu of drug testing conducted by CCHMC's Employee Health Department.*
- ***Medical Questionnaires -*** *a link to complete online medical questionnaires & detailed instructions will be emailed to you directly, within 36 hours prior to attending your pre-employment appointment. Questionnaires must be completed prior to your visit.*

# ☐ Immunizations Required for Employment

| | |
|---|---|
| **COVID-19** | ○ Completed Multi-Dose Series (Pfizer, Moderna, or WHO Validated) ***OR***<br>○ Completed Single Dose Vaccine (Johnson & Johnson) |
| **MMR** | **Rubeola (Measles)**<br>○ 2 Rubeola (Measles) vaccinations with 1 given after 1980 ***OR***<br>○ Positive Rubeola (Measles) IgG titer<br>**Rubella**<br>○ 1 Rubella vaccination ***OR***<br>○ A positive Rubella IgG titer<br>**Mumps**<br>○ 2 Mumps vaccinations ***OR***<br>○ A Positive Mumps IgG titer |
| **HEPATITIS B** | ○ Complete Hepatitis B Immunization series ***OR***<br>○ A positive Hepatitis B Surface Antibody titer |
| **VARICELLA** | ○ A positive Varicella IgG titer ***OR***<br>○ Documentation of 2 doses of Varivax |
| **TDAP** | ○ A TDAP Immunization administered within the last 10 years<br>- TD vaccine only will not meet requirements - TDAP is required |
| **TUBERCULOSIS (TB) TESTING** | Documentation of a recent TB test conducted **within the past 12 months**, and *prior* to start date, with test result details included<br>○ **QFT TB blood test** (Quantiferon Gold or T-Spot) ***OR***<br>○ **2 Step TB Skin Test**<br>- Two separate TB tests are required if a 2-part skin test is conducted. These two separate TB tests must not be completed less than 7 days apart from one other |
| **PAST POSITIVE TB TEST** | ○ Provide documentation of positive results with full details **AND**<br>○ Written Chest X-Ray Report within 6 months of start date |
| **- Other Vaccines -** | ○ Polio vaccine, Tetanus, Pertussis, and other vaccines as needed **AND**<br>○ Other immunizations, including seasonal influenza vaccine*, will be administered if necessary |

* Protecting our patients, families, and staff is our top priority. To help reduce the likelihood of illness for anyone at CCHMC, employees and contractors/vendors/volunteers are required to receive the influenza vaccine each year. The vaccine is provided free of cost to employees and is administered during CCHMC's annual compliance campaigns, which begins between September and November.

If you received the flu vaccine prior to your new hire appointment, you must provide the documentation from your health care provider who administered the flu vaccine. Without proper documentation, you will receive another flu shot during your appointment. Per policy, all employees must receive the flu vaccine between the months of September and April. Latex and preservative free flu vaccines are available.

# World Health Organization Emergency Use Authorization
# Validated COVID-19 Vaccines

| Manufacturer | Vaccine Type | Schedule | Fully Vaccinated | Eligible Ages |
|---|---|---|---|---|
| Pfizer-BioNTech* | mRNA | Two doses, 21 days apart | ≥14 days after second dose | ≥5 years |
| Moderna* | mRNA | Two doses, 28 days apart | ≥14 days after second dose | ≥18 years |
| Janssen (Johnson and Johnson) | Adenovirus vector | One dose | >14 days after dose | ≥18 years |
| AstraZeneca (SK Bioscience) | Adenovirus vector | Two doses, 4-12 weeks apart | ≥14 days after second dose | ≥18 years |
| AstraZeneca (Serum Institute of India) | Adenovirus vector | Two doses, 28 days apart | ≥14 days after second dose | ≥18 years |
| Sinopharm (Beijing Institute of Biological Products Co Ltd) | Inactivated virus | Two doses, 21-28 days apart | ≥14 days after second dose | ≥18 years |
| Sinovac | Inactivated virus | Two doses, 14 days apart | ≥14 days after second dose | ≥18 years |
| Covaxin (Bharat Biotech International Ltd) | Inactivated virus | Two doses, four weeks apart | ≥14 days after second dose | ≥18 years |
| Covovax (Serum Institute of India) | Protein Subunit | Two doses, 21 days apart | ≥14 days after second dose | ≥18 years |
| Novavax | Recombinant Protein | Two doses, 3-4 weeks apart | ≥7 days after second dose | ≥18 years |

*FDA approval received - **8/23/21** (*Pfizer*) & **1/31/22** (*Moderna*)
Last updated 2/28/22

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EMPLOYEE HEALTH DEPARTMENT

# MEDICAL REQUIREMENTS FORM

*** Form to be completed in English ****

## BIOGRAPHICAL INFORMATION

*COMPLETED BY INDIVIDUAL*

**Are you a minor under the age of 18? :** ☐ Yes ☐ No

**Have you ever been badged with CCHMC in the past? (Non-Employee, Volunteer, Previous Employee):** ☐ Yes ☐ No

**Full Name:** *(PLEASE PRINT)* _____

**Date Of Birth:** _____ / _____ / _____ **E-Mail:** _____
*MONTH* *DAY* *YEAR*

**Participating Summer Program :** ☐ SURF ☐ ADHD STP ☐ SMURRF ☐ HS Intern ☐ BRIMS
OTHER: _____

## CONSENT TO CONTACT

*COMPLETED BY INDIVIDUAL & LEGAL GUARDIAN IF UNDER 18*

I, _____, consent to allow Employee Health staff at Cincinnati Children's to contact
(Print Name)
me, or my parent/legal guardian, as necessary, regarding medical information that is provided on this form as well as any medical information relating to employment.

| _____ | _____ | _____ |
|---|---|---|
| ***Signature*** | ***Date*** | ***Phone Number*** |
| _____ | _____ | _____ |
| ***Name of Parent/Legal Guardian (print)*** | ***Relationship*** | ***Phone Number*** |
| _____ | _____ | |
| ***Signature of Parent/Legal Guardian*** | ***Date*** | |

## MEDICAL INFORMATION - COMPLETED BY HEALTHCARE PROVIDER

The medical information included in this section of the form must be filled out by a healthcare provider

***Provider's Name and Credentials (print):*** _____

***Provider's Address:*** _____

_____

***Provider's Phone Number:*** _____

# MEDICAL INFORMATION - COMPLETED BY HEALTHCARE PROVIDER

Medical Requirements for Cincinnati Children's Employees

***** Form to be completed in English *****

| Immunization | Dose 1 Date | Dose 2 Date | Dose 3/Booster Date |
|---|---|---|---|
| **MMR (Measles, Mumps, Rubella)** | | | |
| **Hepatitis B** | | | |
| **Varicella (Chicken Pox)** | | | |
| **TDAP (Tetanus, Diphtheria, Pertussis)** | | | |
| **Covid-19 (include brand name)** | | | |

**For Titers:** Include a copy of titer results with this form

| Antibody IGG Titer | AU/mL | Interpretation (Positive/Negative) | Optional Notes: |
|---|---|---|---|
| **Measles/Rubeola** | | | |
| **Mumps** | | | |
| **Rubella** | | | |
| **Hepatitis B** | | | |
| **Varicella (Chicken Pox)** | | | |

**For TB Tests:** Include a copy of PPD or QFT results with this form & copy of chest x-ray report for positive readings*

| | PPD TB Skin Tests (2 separate required) | Administration Details | Results |
|---|---|---|---|
| 2 Separate TB Skin tests | **PPD TB Test #1** | Test Administration Date: _____<br>Provider Signature & Credentials:<br>_____ | Test Results Date: _____<br>Results:_____mm Induration*<br>Provider Signature & Credentials:<br>_____ |
| ***OR*** | **PPD TB Test #2** | Test Administration Date: _____<br>Provider Signature & Credentials:<br>_____ | Test Results Date: _____<br>Results:_____mm Induration*<br>Provider Signature & Credentials:<br>_____ |
| 1 QFT TB Blood Test | **QFT TB Blood Test** (*Quantiferon Gold or T-Spot)* | Test Administration Date: _____<br>Provider Signature & Credentials:<br>_____ | Results:_____IU/mL<br>**Circle** Results Interpretation: NEGATIVE POSTIVE |

_____ _____ _____

***Date*** ***Signature of Provider Completing Form*** ***Provider's Credentials***

# EMPLOYEE HEALTH – MINOR CONSENT FORM

**Parent/Legal Guardian Information**

Name of Minor: _____ Age:_____ DOB:_____

Name of Legal Guardian: _____Relationship to Minor:_____

Address: _____ City/State/Zip Code: _____

Parent/Legal Guardian Contact Information:

Home/Cell #: _____ Alternative Contact #: _____

Email: _____

*Please **circle** your preferred method of contact*: phone call / email / no preference

## CONSENT TO TEST AND ADMINISTER IMMUNIZATIONS

"I_____, being the parent/legal guardian of _____, do hereby authorize and consent for Cincinnati Children's Hospital Medical Center (CCHMC) to conduct any laboratory tests or to administer any immunizations to my child that are required by CCHMC's infection control policy, or by local, state and federal statutes for the term of their employment.

***Please Initial Below:***

I, _____, also consent to allow my child to submit a preplacement drug test/alcohol screen and further grant permission for blood and/or urine specimens to be collected from my child for the purpose of determining alcohol, controlled substances, and other intoxicants.

I, _____, acknowledge that the specimen collected will be tested for the following drugs/drug classes: Amphetamines, Barbiturates, Benzodiazepines, Cocaine, Ecstasy (MDMA), Marijuana, Methadone, Methaqualone, Opiates, Oxycodone, Phencyclidine, and Propoxyphene.

I, _____, understand that an inconclusive test will be sent to a Department of Human Services certified lab for confirmatory testing of the above drugs.

**I, _____, understand and acknowledge that my child will not be considered for employment at CCHMC if:**

I _____, as their parent/legal guardian, refuse to provide consent to laboratory tests, administering of immunizations, or drug/alcohol testing ***OR*** if after parent/guardian consent is granted, my child, on their own accord, fails to cooperate with any of CCHMC's policies relating to, but not limited to, infection control, employment, and drug-free workplace as well as any local, state and federal statutes, during their pre-employment processing visit.

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Witness Signature Date