

### IMMUNIZATION AND IMMUNITY TESTING POLICY

HelpCare Clinic Healthcare Worker Policies for immunization and immunity are based on current recommendations by the Hospital Infection Control Advisory Committee of the Centers for Disease Control and mandates by regulatory agencies. The term Healthcare Worker (HCW) refers to all individuals who are employed by, or who provide volunteer, contract or education-based services within the Clinic. All volunteers providing medical care directly to patients at HelpCare Clinic are required to attest to the following immunization/immunity testing. It is strongly suggested that all other volunteers at HelpCare Clinic also are up to date on these immunizations.

### IMMUNIZATION RECORD

<b>** <i>REQUIRED Immunization/Immunity Testing</i></b>
<b>MMR-Measles</b> (Rubeola), <b>Mumps</b> , <b>Rubella</b> (German Measles) —One of the following is required if born after 12/31/56
<ul style="list-style-type: none"><li>o Laboratory documentation of immunity to measles, mumps, and rubella(positive antibody test).</li><li>o Documentation of two (2) doses of r MMR received after your first birthday.</li></ul>
<b>Tdap</b> (Tetanus, Diptheria Pertussis)
<ul style="list-style-type: none"><li>o o Documentation of one (1) dose of Tdap vaccine within the past 10 years.</li></ul>
<b>Hepatitis B series</b> —One of the following is required for health care workers
<ul style="list-style-type: none"><li>o Laboratory documentation of immunity to hepatitis B (positive antibody test)</li><li>o Documentation of three (3) doses of hepatitis B vaccine</li></ul>
<b>Varicella</b> (Chickenpox) – One of the following is required if born after 12/31/56
<ul style="list-style-type: none"><li>o Laboratory documentation of immunity to varicella zoster virus (positive antibody test).</li><li>o Documentation of two (2) doses of Varivax (Chickenpox Vaccine).</li></ul>
<b>Flu Vaccination</b>
<ul style="list-style-type: none"><li>o <b>Documentation of vaccination within last 12 months</b></li></ul>

Signature\_\_\_\_\_Date\_\_\_\_\_

**\*\* If not providing documentation of Measles, Mumps, Rubella, Tdap, Hepatitis B series, Varicella and flu vaccination, I attest that I have had the diseases or that I have been adequately immunized.**

**Signature\_\_\_\_\_Date\_\_\_\_\_**