

ThedaCare

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ThedaStar Air Medical Participant Health Status

Name: _____

Address: _____ Phone Number: _____

The above named participant has had a physical examination on _____, and was found able to physically function in the participant capacity.

He/she is free from Communicable Disease as indicated by the * attached laboratory results : a) Immunization documentation/history of disease cannot be used in lieu of titers/tests.

Individuals who test non-immune to Rubella, Mumps, and Rubeola {measles} must be immunized and titer rechecked to document immunity.

Individuals who are non-immune to VZ {chickenpox} must review the hospital policy related to those employees who are chickenpox non-immune. Immunization and re-titer is highly recommended.

A negative PPD (TM skin test) must be documented **within the last 6 months**. If a positive skin test is found, appropriate follow-up must be documented.

PPD:

Date placed: _____ Date read: _____ Results: _____ mm induration

Two step PPD: (Only if needed)

Date placed: _____ Date read: _____ Results: _____ mm induration.

If (+) PPD Date: _____

Date and results of chest x-ray: _____

Took INK Yes _____ No _____ For how long? _____

Send a copy of TB Assessment Questionnaire

Actual Lab results/Lab sheets for the following titers MUST be attached in order to be considered for a Ride Along experience:

a) Rubella Titer c) Mumps Titer

b) Rubeola (Measles) Titer d) VA (Chickenpox) Titer

> Hepatitis B immunization and antibody titer is voluntary, but highly recommended for any observer who may come in contact with patient blood and/or certain body fluids.

Ride along participant is immunized? No _____ Yes _____ Titer +/- (circle one)

> Hepatitis C antibody titer is voluntary, but highly recommended for any observer who may come in contact with patient blood and/or certain body fluids.

Ride along participant is immunized? No _____ Yes _____ Titer +/- (circle one)

Signature of health care provider verifying above information Date

(Print name of health care provider): _____

(Address of health care provider): _____

*** If questions, call 920-729-2114**