# Medical Information Required

***SUBMIT PROOF OF THE FOLLOWING TO OCCUPATIONAL HEALTH:***

***□ TWO*** ***MMR*** vaccinations (**M***easles,* **M***umps, and* **R***ubella*) if born 1957 and after. You must show proof that you have had two doses of MMR. Titers (blood work showing the immunity levels) are acceptable in lieu of vaccination records.

***□ TWO CHICKEN POX (Varicella)*** are required either through immunization record, physician certification of chicken pox or proof by titer. Titers (blood work showing the immunity levels) are acceptable in lieu of vaccination records.

* If your immunization record only notes a history of the disease for Varicella, you must have a titer (blood work done at your own expense) to show you developed an immunity to the disease.

* If you have only had half of each vaccination series (*1 MMR and/or 1 Varicella*), you must consult with your doctor on finishing the series or having blood work drawn to show immunity.

***□ TWO SEPARATE PPD/TB (Tuberculosis)*** tests within the last 12 months, or if positive PPD, Chest X-Ray or T-Spot within last 6 months.

* Occupational Health administers PPD tests Monday-Friday (*except on Thursdays*-*free of charge*). You will have to return to Occupational Health 2 days later to have it read (*Ex. Placed on Monday read on Wednesday*).

* If you have had a TB test done within the last year please bring those records with you to Occupational Health.

***□ THREE Hep-B***

***□ ONE Tdap (or FIVE dTap)***

***□ COVID-19: to be fully vaccinated (2 doses of Moderna or Pfizer or 1 dose of Johnson & Johnson; 2 weeks after receiving 2nd dose)***

***□ FLU VACCINATION during flu season***.

* A flu shot will be provided free of charge by Occupational Health as part of your medical clearance. ***Mandatory during flu season only***.
* If you have received a flu shot from another location – i.e. a pharmacy, primary care physician, etc. please provide Occupational Health with proof of vaccination.

***\*If you have any questions, please contact Occupational Health: Tel: (410) 550-0477, Fax: (410) 550-0732, Email: OHSClinic@jhmi.edu***



### Johns Hopkins Bayview Occupational Health Services

5300 Alpha Commons Drive, Suite 105 Baltimore MD 21224

**Tel:** 410-550-0477 **Fax:** 410-550-0732 **Email:** OHSClinic@jhmi.edu

# MEDICAL CLEARANCE FORM

(Applicant please complete Name and Birthdate ONLY)

**Program Name**: \_\_\_\_Volunteer Services\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Applicant Name**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Birthdate**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Documentation of the following is required for clearance: (To Be Used Only by OHS Office)

* 2 Varicella (or Titer) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* 2 MMR (or Titer) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* 3 HEP B (or Titer) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* 1 Tdap \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* 2 PPD tests (or T-Spot) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* COVID-19 vaccination(s)1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Flu Vaccination (during season) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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RN Signature Date of Clearance