

Student Health Screening Form

The following form must be forwarded to Staff Health at least 1 week prior to commencement of your placement. All students are required to provide evidence of protection against the specified infectious diseases below and the vaccination for HCW requirements as per Department of Health Regulations outlined in Gippsland Southern Health Services' Staff Health Policy.

Placement will be suspended if all information is not received prior your commencement date. If you are unsure how to answer the below screening questions please contact the Education Department on (03) 5667 5502 or email education@gshs.com.au. All information provided is confidential and Education will contact you if any follow-up is required before your placement begins.

Name:									
Address: Postcode:									
OB: Telephone:									
Allergies: University:									
Placement commencement date:									
Placement commencement date: Length of Placement (weeks):									
Hamatikia B Barruinamantu									
Hepatitis B Requirement:									
Documented 3 doses of Hepatitis B or combination HepA/HepB vaccination Attach Evidence									
AND			I						
Documented Hepatitis B antibody levels post vaccination	Yes	No	HBsAb Le	evel:IU/L	Attach Evidence				
Measles Mumps Rubella (MMR) Requirement:									
Documented 2 doses of MMR Vaccination	Yes	No			Attach Evidence				
OR									
Serological evidence of immunity	Attach Evidence								
Varicella (Chickenpox) Requirement:	[2.0					
Have you had Chickenpox?	Yes	No	Unsure	Year:	Attach Evidence				
OR									
Documented 2 doses of VZV Vaccination	Attach Evidence								
OR .									
Serology to confirm immunity to VZV	Attach Evidence								
Influenza:									
Previous Influenza Vaccination	Yes	No	Unsure	Date:	Attach Evidence				
The state of the s	1.00	1.0	51.5415	_ 3.00					
Pertussis (Whooping Cough):									
Previous Boostrix Vaccination	Yes	No	Unsure	Date:	Attach Evidence				

Tuberculosis:									
Previous Tuberculin Sk Gold Test	in Test or Quantiferon TB	Yes	No			Attach Evidence			
Have you have previous suspected TB cases?	s contact with known or	Yes	No						
County of Birth:									
Countries where you have lived or worked for more than 3 months including the year of residence/travel:									
Childhood Immunisat	ions:								
Have you completed yo	our childhood immunisations?	Yes	No	Unsure		Attach Evidence			
Other:									
	of the administration of any ot	her vac	cinatio	ons not liste	ed above				
	•								
<u>C</u>	Office Use Only – Follow-up F	Require	ed – T	o be comp	leted by Staff Health				
Comments/Actions:									
Date									

Date Received: