Hartford HealthCare
The Hospital of Central Connecticut

Hartford HealthCare
MidState Medical Center

Campus: □ MSMC □HOCC □ BMH

To be completed by your physician and any required immunization records should be attached.

VOLUNTEER NAME (print):_____ Date of Birth _____

MMR (Measles, mumps and rubella) **Two doses OR evidence of positive titer is required for all volunteers**

Date MMR #1:_____Date MMR #2: _____OR Date of positive titer_____

VARICELLA (Chickenpox) **History of disease OR 2 doses of vaccine OR evidence of positive titer required**

Date of disease_____OR Dates of immunization #1____#2 _____OR Date of positive titer_____

INFLUENZA: Proof of flu vaccine during flu season (November – May) _____

Tdap: Proof of one dose of Tdap (Tetanus-Diphtheria-Pertussis) administered at or after the age of 18.

In the event that vaccination records are unavailable, you must have immunity verified through blood titers, and if necessary, you must be vaccinated prior to volunteering. Please inquire with the Volunteer Services staff contact for instructions on how to schedule an appointment at the hospital.

TB TESTING: One skin test or Quantiferon blood test completed must be within the last 12 months:

Date Given_____Date read_____Result _____

If TB skin test is positive (or volunteer has a history of a positive test or vaccination with BCG):

IGRA test result:_____Date_____If IGRA test is positive: Chest X-ray result_____Date_____

If Chest X-ray is positive: Date treatment completed _____

_____ _____

Physician's Signature **Date**

_____ _____

Physician's Address **Physician's phone number**