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 Benalla Health's 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 Staff Health Coordinator on (03) 5761 4733 or email louise.carrington@benallahealth.org.au. All information provided is confidential and Staff Health will contact you if any follow-up is required before your placement begins.

Name:	
Address:	**Postcode: .....**
DOB:	**Telephone: .....**
Allergies:	**University: .....**
Placement Discipline:	**Student Year: .....**
Placement commencement date: ..... Length of Placement (weeks):	

Hepatitis B Requirement:				
Documented 3 doses of Hepatitis B or combination HepA/HepB vaccination				Attach Evidence
AND				
Documented Hepatitis B antibody levels post vaccination	Yes	No	HBsAb Level: .....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:					
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

Pertussis (Whooping Cough):					
Previous Boostrix Vaccination	Yes	No	Unsure	Date:	Attach Evidence

Tuberculosis:				
Previous Tuberculin Skin Test or Quantiferon TB Gold Test	Yes	No		Attach Evidence
Have you have previous contact with known or suspected TB cases?	Yes	No		
County of Birth:				
Countries where you have lived or worked for more than 3 months including the year of residence/travel:				

Childhood Immunisations:					
Have you completed your childhood immunisations?	Yes	No	Unsure		Attach Evidence

Other:
Please attach evidence of the administration of any other vaccinations not listed above

Office Use Only – Follow-up Required – To be completed by Staff Health	
Comments/Actions:	
Date	
Date Received:	