Baycrest Volunteer Immunization Record

Name of Volunteer Applicant:

The following form is to be completed by your healthcare provider. Please email the completed form to volunteer@baycrest.org or send by fax to 416-785-2850.

If you have questions about this form or the immunization requirements, please contact Volunteer Services at volunteer@baycrest.org or 416-785-2500 ext. 2572.

Part 1

☐ I confirm **MEASLES IMMUNITY** (proof of immunity as outlined below):

- Documentation of having received 2 doses of measles containing vaccine on or after the first birthday, OR
- Laboratory evidence of immunity to measles.

☐ I confirm **MUMPS IMMUNITY** (proof of immunity as outlined below):

- Documentation of having received 2 doses of mumps containing vaccine given at least 4 weeks apart on or after the first birthday, OR
- Laboratory evidence of immunity to mumps.

☐ I confirm **RUBELLA IMMUNITY** (proof of immunity as outlined below):

- Documentation of having received a single dose of a rubella containing vaccine on or after the first birthday OR
  Laboratory evidence of immunity to rubella.

☐ I confirm **VARICELLA IMMUNITY** (proof of immunity as outlined below):

- Documentation of having received 2 doses of varicella containing vaccine, or
- Laboratory evidence of immunity to varicella.

☐ I confirm **PERTUSSIS IMMUNITY** (proof of immunity as outlined below):

- Adult volunteer - Documentation of having received one dose of T-dap (Tetanus-diphtheria acellular pertussis) as an adult.
- Adolescent volunteer - Documentation of having received the adolescent T-dap (Tetanus-diphtheria acellular pertussis) booster.

☐ I confirm **HEPATITS B IMMUNITY (RECOMMENDED)** (proof of immunity as outlined below):

- Laboratory evidence of immunity to Hepatitis B

Part 2

FOR COMPLETION BY PHYSICIAN or other HEALTH CARE PROVIDER GIVING CLEARANCE TO THE VOLUNTEER

I am aware of the communicable disease screening requirements as outlined above and certify that

_____ meets all requirements.
(Name of Volunteer Applicant)

_____ _____
Signature of Physician/Other Health Care Provider Date

Clinic Stamp (REQUIRED)