CHILDREN'S MINNESOTA: VOLUNTEER IMMUNITY REQUIREMENTS

Evidence of immunity is a requirement prior to volunteering in any capacity at Children's Minnesota. Evidence of immunity is defined as *written documentation* of: 1: immunization record (i.e. copy of immunization record card, MIIC printout) **OR** 2: written statement from healthcare provider verifying disease diagnosis (i.e. in the case of chickenpox), **OR** 3: copy of laboratory result confirming disease or immunity (i.e. serology results).

You can either submit your immunization records, OR have your healthcare provider fill out and submit this form (we do not need both).

Volunteer Services Fax: (612) 813-6147
Email: volunteerservices@childrensMN.org please indicate 'Imms-Mpls' or 'Imms-St. Paul' in subject line

If verifying via this form, the following is to be completed using (MM/DD/YY) format & signed by healthcare provider:

Applicant Name: _____Date of Birth: _____

Provider Name: _____ **Signature**: _____ Today's Date: _____
****Provider: when signing this form, please include your credentials (MD, PA, RN, etc.)****

REQUIRED:

1. **TUBERCULOSIS** – one of the following is required:
   - ☐ Negative **2 step** Mantoux skin test (**two** negative TSTs) Date #1:_____ Date #2:_____
   - ☐ Negative Quantiferon Gold blood test (QFT) within the last 12 months. Date:_____
   - ☐ Negative T- SPOT test within the last 12 months. Date:_____
   - ☐ Negative chest x-ray (if done as follow-up for positive Mantoux) from within last 12 months. Date:_____
   - ☐ Completed treatment of active disease. Date:_____

2. **CHICKENPOX*** (varicella) – one of the following is required:
   - ☐ Written documentation of two doses of varicella or MMRV vaccine.
     Date dose #1:_____ Date dose #2:_____
   - ☐ Written documentation of one dose of varicella and one dose of Zostavax (ZVL) for shingles *(any other shingles vaccine will not satisfy one dose.)* Date dose #1:_____ Date dose #2:_____
   - ☐ History of chickenpox or shingles based on healthcare provider diagnosis. Date of disease:_____
   - ☐ Laboratory confirmation of chickenpox disease or immunity to chickenpox. Date of lab test:_____

3. **MEASLES*** (rubeola) - one of the following is required:
   - ☐ Written documentation of two doses of MMR or MMRV vaccine.
     Date dose #1:_____ Date dose #2:_____
   - ☐ Laboratory confirmation of measles disease or immunity to measles. Date of lab test:_____

4. **MUMPS*** – one of the following is required:
   - ☐ Written documentation of two doses of MMR or MMRV vaccine.
     Date dose #1:_____ Date dose #2:_____
   - ☐ Laboratory confirmation of mumps disease or immunity to mumps. Date of lab test:_____

5. **RUBELLA*** - one of the following is required:
   - ☐ Written documentation of one dose of MMR or MMRV vaccine. Date:_____
   - ☐ Laboratory confirmation of rubella disease or immunity to rubella. Date of lab test:_____

6. **PERTUSSIS*** – the following is required:
   - ☐ Tdap vaccine. Date:_____

7. **COVID-19** - the following is strongly encouraged:
   - ☐ COVID-19 vaccine. Date of last vaccine:_____

8. **INFLUENZA*** – the following is strongly recommended:
   - ☐ **Yearly** influenza vaccination during influenza season (generally October – April). Date:_____

*CDC. Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP). MMWR; 60(RR-7).