

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

To ensure the safety of patients, clients and staff, all individuals accepted/invited to observe or shadow our faculty and clinical staff within UCLA Health must be screened for potentially infectious diseases and conditions, as recommended by the Centers for Disease Control and Prevention. Individual must obtain medical clearance, as delineated on this form, by a licensed healthcare provider prior to starting their observations within UCLA Health premises.

**NOTE: Proof of each medical clearance items must be sent to the coordinator in addition to this form.**

1. Immunity to Measles, Mumps, Rubella and Varicella - Individual must have proof of immunity, (e.g. blood titers) to the following conditions or vaccination records for 2 MMR and 2 Varicella Vaccines.

MMR Vaccine #1: \_\_\_\_\_ MMR Vaccine #2: \_\_\_\_\_ OR Positive Titer Date: \_\_\_\_\_

Varicella Vaccine #1: \_\_\_\_\_ Varicella Vaccine #2: \_\_\_\_\_ OR Positive Titer Date: \_\_\_\_\_

Comments: \_\_\_\_\_

2. COVID Vaccine – Individuals must either have completed primary COVID vaccine series (Two Moderna/Pfizer OR One J & J) along with subsequent booster OR have received one Bivalent Booster. Individuals may also decline the vaccine by signing a declination (Addendum I).

Type of vaccine: \_\_\_\_\_ Date of Vaccine #1: \_\_\_\_\_ Date of Vaccine #2: \_\_\_\_\_

Booster Type: \_\_\_\_\_ Date: \_\_\_\_\_

**OR**

Bivalent Booster: \_\_\_\_\_ Date: \_\_\_\_\_

3. Tuberculosis Testing - Individual must be tested for Tuberculosis by Quantiferon (QFT) blood test or TSpot AND be free of active tuberculosis. TB Skin tests are not acceptable. If individual has history of positive TB test, a negative chest X-ray is required in lieu of a TB blood test. TB blood test/X-ray must be completed within the last 3 months.

TB Test Type (Blood test or X-ray): \_\_\_\_\_ TB Result: \_\_\_\_\_ Date of TB Test: \_\_\_\_\_

4. Tetanus-diphtheria-pertussis Vaccine - Individual must either have documentation of Tdap (Tetanus, Diphtheria, and Pertussis) vaccine or sign a declination for the Tdap vaccine (Addendum II).

Has individual been vaccinated for Tdap? If yes (add date here): \_\_\_\_\_ No (declination signed): \_\_\_\_\_

5. Hepatitis B Vaccination - Individual must either demonstrate immunity to Hepatitis B (blood titers), or sign a declination for Hepatitis B vaccine (Addendum III).

6. Flu Vaccine - Required annually during flu season (November-April) only.

Date of Flu Vaccine: \_\_\_\_\_

General Comments: \_\_\_\_\_

**Licensed Healthcare Provider Statement:**

I certify that this individual has met the above-described health clearance criteria and does not represent a communicable disease safety risk or risk in a hospital environment.

Licensed Healthcare Provider Name \_\_\_\_\_ License # \_\_\_\_\_

Office Phone (\_\_\_\_\_) \_\_\_\_\_ Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

# Addendum I

## COVID Vaccine Declination

The University of California strongly recommends that all members of the University community, except those who have had a severe allergic reaction to a previous dose of the COVID-19 vaccine or any of its components, receive a vaccination to protect against COVID-19 disease as soon as they are eligible as well as receive boosters as needed to stay up-to-date.

You have requested to decline receiving the COVID-19 vaccine and/or applicable booster(s). Please review the information below and then select the best reason as to why you are declining the COVID-19 vaccine and/or applicable booster(s).

I am aware of the following facts:

- COVID-19 is a serious disease and has killed over 1 million people in the United States since February 2020, 100,000 in California alone.
- The COVID-19 vaccine is recommended for me and other members of the University community to protect our students, patients, faculty, staff, and our families and communities from COVID-19, its complications, and death.
- If I contract COVID-19, I can spread the virus for days even before any symptoms appear. During the time I spread the virus, I can transmit it to anyone I contact.
- If I become infected with SARS-CoV-2, the virus that causes COVID-19, even if my symptoms are mild or non-existent, I can spread the disease to others, and they can become seriously ill or die as a result.
- Nearly 1 in 5 American adults who have had COVID-19 is estimated to be suffering from "Long COVID" - symptoms that can last months or years after COVID-19 and can be debilitating.
- Contracting COVID-19 could have life-threatening consequences for my health and the health of everyone with whom I have contact, including my coworkers, peers and the most vulnerable members of our community.

Despite the above facts, I am voluntarily declining the COVID-19 vaccine(s). My reason(s) for declining are as follows:

- Medical contraindication       Concerned about risks of vaccine more than risks of disease
- Disability       Want to delay but intend to get boosted
- Religious objection       Prefer not to say
- Other: \_\_\_\_\_

I understand that I can change my mind at any time and receive the COVID-19 vaccine and/or applicable booster(s). I understand that as long as I am not up-to-date on the COVID-19 vaccination status, I may be required to take precautionary measures as required by my location, such as wearing a mask and increased testing.

I have read the information on this Vaccine Declination Statement, and I am aware I have the ability to ask questions at any time of my supervisor.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of Birth

# Addendum II

## Tdap Vaccine Declination

I understand that as an Observer at UCLA Health I may be exposed to aerosol transmissible diseases and may be at risk of acquiring infection with Pertussis. The Tdap vaccination is strongly recommended for all volunteers.

Please visit your primary care physician to obtain the Tdap vaccination. Individuals with extenuating circumstances that cannot obtain the vaccination from their PCP may contact Volunteer Services for further assistance.

**Please indicate below if you have received the Tdap vaccination (must have been administered after AGE 12, and within 10 years) or choose to decline.**

I am declining because I choose not to have the Tdap vaccination. I am aware that I may change my mind at a later date.

I have already received a Tdap vaccination (after age 12 and within 10 years). I have a record or know the date and location of that vaccination.

I have already received a Tdap vaccination. I do not have a record or cannot recall when I received the vaccination.

Other \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of Birth

# Addendum III

## Hepatitis B Vaccine Declination

I understand that as an Observer at UCLA Health I may be exposed to blood or other potentially infectious materials and may be at risk of acquiring hepatitis B virus (HBV) infection. The Hepatitis B Vaccination is strongly recommended for all volunteers.

Please visit your primary care physician to obtain the Hepatitis B Vaccination. Individuals with extenuating circumstances that cannot obtain the vaccination from their PCP may contact Volunteer Services for further assistance.

### Please check appropriate box:

I decline Hepatitis B vaccination at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring hepatitis B, a serious disease.

I decline the Hepatitis B vaccination series due to the following reason:

I have previously completed a Hepatitis B 3-vaccine series with written documentation and choose not to repeat the vaccine series at this time.

I have previously completed a Hepatitis B 3-vaccine series, but I do not have written documentation and choose not to repeat the vaccine series at this time.

I have been diagnosed with Hepatitis B in the past.

Other \_\_\_\_\_

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date of Birth