Mercy Medical Center Volunteer Health Form

Name:_____ Date of Birth:_____

Home #:_____Work #:_____Cell #:_____

Meds:_____

Allergies:_____

Health Problems:_____

_____

Documentation for TB test and immunizations is required. An official copy (typed or faxed from the physician's office, city health nurse or UWO health center) or a copy of physician documentation in childhood health record should be attached to this form when submitted. Hand written notes are not accepted. You may be able to access your immunization record at the Wisconsin Immunization Registry (WIR) http://dhfsWIR.org

Health requirements & policies apply to all volunteers in patient care areas. It is the volunteer's responsibility to submit accurate and timely information. To the best of my knowledge, the above information is correct, and I do not currently have a communicable disease or health condition that would put me or clients that I have contact with at risk.

_____ ___/___/___ _____ ___/___/___

Volunteer Signature Reviewer Signature

FOR OFFICE USE ONLY

***TB Skin Test** 2 Step Needed: YES_____ NO _____

#1 Date: ___/___/___ Date Read: ___/___/___
Lot #_____ Results:_____ Expiration Date: ___/___/___

#2 Date: ___/___/___ Date Read: ___/___/___
Lot #_____ Results:_____ Expiration Date: ___/___/___

Date of past positive: ___/___/___ **QFT**: ___/___/___ **CXR**: ___/___/___

***MMR**
#1 Date: ___/___/___
#2 Date: ___/___/___

Rubella Titer: Date: ___/___/___ Results: _____
Rubeola Titer: Date: ___/___/___ Results: _____
Mumps Titer: Date: ___/___/___ Results: _____

***Flu Vaccine** Date: ___/___/___

***Tetanus** Date: ___/___/___

***Chicken Pox (Varicella)**
Disease: YES _____ NO _____
Vaccine: #1 Date: ___/___/___ #2 Date: ___/___/___
Titer: Date: ___/___/___ Results: _____

Health form approved by: _____ **Date: ___/___/___**
(NURSE'S INITIALS)

If under age 18 or under legal guardianship please complete reverse side

PARENT/GUARDIAN AGREEMENT FORM

To Be Completed by Parent/Guardian if volunteer is under the age of 18 or requires legal guardianship.

I give permission for (name of applicant) _____
to participate in the **volunteer** program at Mercy Medical Center. I understand that volunteer assignments are scheduled on a regular basis and that my child is expected to report as assigned or follow the procedures for finding a substitute.

I am aware that service hours will not be validated/verified for employment or scholarship recommendations, secondary education application forms and/or other forms of reference letters in the event that the applicant volunteers less than 50 hours.

I certify that the applicant is _____ years of age with a birth date of ___/___/___.
I authorize the necessary care and treatment of the applicant in the event of a medical emergency. I authorize any screening that is required for participation in the volunteer program. This may include TB skin test/s, a flu vaccine, and a lab draw to test for immunities to mumps, measles, rubella and varicella (chicken pox). I also give permission for any future TB skin tests, lab draws or flu vaccines.

I have reviewed this health and parent/guardian agreement form. My signature below serves as acceptance and acknowledgement of the required authorizations of Mercy Medical Center's volunteer program. If I have any questions or concerns I will contact the Volunteer Services Office at (920) 223-0225.

Signature of Parent or Guardian _____ Date _____