HSHS Sacred Heart St.Joseph's

VOLUNTEER HEALTH SCREENING
Confidential Record

Last Name:_____ First Name:_____ M.I. _____ Nick Name: _____

Address:_____ Date of Birth: _____/_____/_____

City:_____ State:____ Zip:_____

COMMUNICABLE DISEASE AND IMMUNIZATION HISTORY:

Please check applicable…	I have HAD this disease	I have NOT had this disease	IF IMMUNIZED, PROVIDE DATES
Chicken Pox	☐	☐	_____
Diphtheria	☐	☐	_____
Hepatitis A	☐	☐	_____
Hepatitis B	☐	☐	_____
Hepatitis C	☐	☐	_____
Measles	☐	☐	_____
Mumps	☐	☐	_____
Pertussis (Whooping Cough)	☐	☐	_____
Polio	☐	☐	_____
Rubella (German Measles)	☐ *(provide results)	☐	_____
Tetanus	☐	☐	_____
Tuberculosis (TB)	☐ *(provide results)	☐	_____

MEDICAL HISTORY:

Do you have any health conditions, physical restrictions or mental disorders that may affect your ability to perform as a volunteer in the hospital?
☐ No ☐ Yes. If yes, please describe: _____

_____

Injuries/Fractures; Hospitalization/Surgeries:_____

_____

Are you currently under medical treatment? ☐ No ☐ Yes. If Yes, please indicate the condition(s) and medication(s) that is/are being treated and the physician who is treating the condition(s): _____

_____

CHECK ANY ILLNESSES YOU HAVE HAD OR NOW HAVE:

☐ Asthma
☐ Back injury
☐ Diabetes
☐ Disorders of bones
☐ Heart disease or murmur
☐ Hypertension
☐ Joints or muscular system
☐ Liver disease
☐ Mental Health
☐ Seizures

I certify my answers to the above to be true and correct to the best of my knowledge.

Signature of Applicant (Parent or Guardian if Minor) _____ Date_____

INTERNAL – DEPT USE ONLY:

VOLUNTEER SERVICES:
Junior: ☐ Adult: ☐ Patient Contact: Yes ☐ No ☐ Volunteer Area(s): _____

EMPLOYEE HEALTH NURSE:
Date of last TB skin test: _____ Date Resulted: _____ mm Induration: _____
Date of last chest x-ray (If history of previous positive TB skin tests): _____