Volunteer Staff Health Screen

Name:________________________________ Date: ___________________________

DOB: ________________________________ Emergency Contact Name: ___________

Phone #:______________________________ Phone#: ____________________

Local Address: _________________________ Relationship:_________________

This is a health screening and is not intended to replace your annual physical by your Primary Care Provider. If you are able to provide a copy of your most recent physical (within 1 year) you may forego a physical examination.

Please complete the following information:

Immunizations: Please provide proof of immunizations or Lab Titers to prove immunity to: Chicken Pox/Shingles, Measles, Mumps, Rubella (German Measles), Rubeola (Red or Hard Measles). If you are unable to do so, we will order Lab Titers.

Medications: Please list any prescription medications or over the counter medications you are currently taking.	**Allergies:** Please list any known allergies, including medication and environmental.

LATEX ALLERGIES: Please check Yes or No for each question:	**Yes**	**No**
Do you have any known latex sensitivity?		
Have you ever filled out the long Latex Sensitivity Questionnaire?		
Do you have a history of allergic reactions after eating fruit?		
Have you ever noticed a rash, swelling, shortness of breath, cough, wheezing, runny nose, sneezing, or itchy eyes while using latex or rubber products?		
Has a doctor ever said you had an allergic reaction or problem of unknown cause during surgery or a hospitalization?		

Do you have any changes in and/or chronic health conditions/illness that we should be aware of? (Heart disease, seizures) NO YES

If Yes, please explain:

Volunteer Signature: ____ **Date:** ___________

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services."

Employee Health Nurse Signature: ________________________ **Date/Time:** ____________

Hepatitis B Vaccination Declination:
I have discussed this with the employee health nurse.
I understand that as a volunteer, due to a potential exposure to blood or other potentially infectious materials, I may be at risk of acquiring hepatitis B virus (HBV) infection. I have been given the opportunity to be vaccinated with hepatitis B vaccine; however I decline hepatitis B vaccination at this time. I understand that by declining this vaccine I may be at risk of acquiring hepatitis B, a serious disease. If in the future I continue to volunteer with potential exposure to blood or other potentially infectious materials and I want to be vaccinated with hepatitis B vaccine, I can receive the vaccine series at no charge to me.

Volunteer Signature:	**Date:**

TO BE COMPLETED BY EMPLOYEE HEALTH NURSE:

	Volunteer provided Physical from Primary Care Provider. See attached.

Height	Weight	BP	HR	Resp	Temp

Heart Sounds:

Lung Sounds:

Immunizations given (please complete immunization consent forms for each):

Nurse Comments: ____
____
____
____

Outcome: _____No significant health concerns to address.
_____Physical referral recommended.

Employee Health Nurse: _________________________________ **Date/Time:** ____________