

Name: _____ Date: _____

DOB: _____ Sex: M F Emergency Contact Name: _____

Social Security Last 4 #s ONLY: _____ Phone#: _____

Phone #: _____ Relationship: _____

Local Address, City, State, Zip: _____

This is a health screening and is not intended to replace your annual physical by your Primary Care Provider. If you are choose to provide a copy of your most recent physical (within 1 year) you may forego a physical examination. Your Volunteer Health Screening appointment should be at least 3 days prior to your start date.

Please complete the following information:

Immunizations: Please provide proof of immunizations or immunity to: Chicken Pox/Shingles, Measles, Mumps, Rubella (German Measles), Rubeola (Red or Hard Measles), Tetanus, Diphtheria, Pertussis (Tdap) or Tetanus (Td), Seasonal Influenza (Flu). If you are unable to do so, we will order Lab Titers to ensure immunity.		
TB Test: Negative TB Test (2-step or T Spot) within 1 year of start date. If you have a history of a Positive TB Test, then please provide your MOST RECENT Chest X-Ray.		
*** If you need additional immunizations to volunteer for UnityPoint Health Finley Hospital, we are happy to provide these immunizations at Finley Employee Health or Finley Occupational Health at no cost to you. Obtaining these immunizations elsewhere is at your own expense. ***		
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:** _____

Volunteer Name: _____ NEW Volunteer Health Screening

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 from Finley Employee Health or Finley Occupational Health at no charge to me. Obtaining these immunizations elsewhere is at your own expense.

Volunteer Signature:

Date:

RELEASE OF INFORMATION:

I authorize that Finley Occupational Health/Finley Employee Health/The Finley Hospital may disclose all or any part of my record to any authorized person or corporation which is or may be liable for all or any part of the clinic/hospital charges, including but not limited to insurance companies, external review organization, workers' compensation carriers or employers.

Volunteer Signature:

Date:

Volunteer Name: _____ NEW Volunteer Health Screening

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:** _____