

TB tests will be given at orientation. They are also given in Employee Health on Monday – Friday except Thursday. Return 2 days later for results. Call 456-4485 for an appointment.

STUDENT/JUNIOR VOLUNTEER HEALTH SCREENING

Name: _____ Parent or Guardian: _____
Address: _____ Phone # _____
Age: _____ Date of Birth _____ Physician: _____

Medical History (Check those you have or have had)

- | | | |
|---|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Backaches & Strain | <input type="checkbox"/> Dermatitis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding (excessive) | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Fainting Spells |
| <input type="checkbox"/> Paralysis | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Tuberculosis or Positive TB Test | | |

TB Risk Screening- Please check any of the following that apply to you:

- Close contact with someone suspected of having TB
- Born in Asia, Africa, Latin America, Eastern Europe, Russia
- Resident or employee of correctional institution, nursing home, homeless shelter, long-term residential facility
- Health care worker for high-risk clients
- High-risk racial or ethnic populations including Asian & Pacific Islands, Hispanic, African American, Native American, migrant farm workers, homeless persons
- Previously have injected illicit drugs

Have you had the disease or received immunizations for the following: (Date of last shot)

- | | | |
|--------------------------------------|--------------------------------------|----------------------------------|
| <input type="checkbox"/> M, MR, MMR | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Tetanus |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Influenza | | |

Do you have any present health problems? _____ If yes, describe: _____

Have you had any serious injuries or illness? _____

Do you have any communicable diseases? _____ If yes, describe: _____

I hereby authorize my child to have a TB test as a condition of volunteering.

Signature of parent _____ Date _____