Volunteer Health

For Office Use Only

Volunteer's Campus Assignment _____

Previous Volunteer? Yes _____ No _____

TB Positive ____ Negative____

Hepatitis B Positive ____ Negative____

Wisconsin Administrative Code requires that a health history containing communicable disease history and immunizations be completed by the volunteer before he/she assumes, duties in a healthcare facility. Please complete the questionnaire to the best of your knowledge. All personal health information is confidential and is maintained by the Human Resources Department.

Personal History

Name _____ Date of Birth _____

Address _____

Social Security # _____ Phone Number _____

Please indicate "yes" or "no" with a checkmark in the appropriate square if you have/or have had any of the following conditions.

	Yes	No	Comments
Allergies			
Allergies to Latex			
Asthma or hay fever			
Chest pain or pressure			
Chronic cough or bronchitis			
Convulsive seizures			
Diabetes			
Fainting or dizziness			
High or low blood pressure			
Nervous or mental disorder including but not limited to depression			
Pain or injury to arms or hands			
Pain or injury to knees, feet, or ankles			
Pain or injury to neck, shoulder, or back			
Painful flat feet			
Cancer			
Rheumatic fever or heart trouble			
Rhuematism or arthritis			
Shortness of breath			
Hepatitis			
HIV Infection			
Hearing loss			
Vision Impairments			

Do you have any permanent physical, mental, or learning disabilities? Yes _____ No _____

If yes, what are they?

_____

Do you have any physical or mental limitations which will require accommodation in order to perform the assigned volunteer duties? Yes _____ No _____

If yes, please list the accommodation that you are requesting:

_____

_____

Immunization	Yes	No	Comments
Have you ever received the Influenze vaccine?			Last Dose:
Have you received Tetanus/Diphtheria (TD) immunization?			Last Dose:
Have you received the series of Hepatitis B Vaccine?			Last Dose:
Have you ever received Rubella immunization or do you have confirmed immunity against Rubella?			Last Dose:
Have you had Chickenpox?			
Have you ever received the Varicella Vaccine?			
Have you had a recent TB skin test?			
Have you received BCG vaccine?			
Have you previously had a positive TB skin test?			Date:
If yest to a positive TB skin test, did you receive INH therapy?			Date:

Current Medications: _____

_____

Known Medication Allergies: _____

_____

Personal Medical Doctor: _____ Phone Number: _____

Date of Last Physical: _____

_____

Signature Date

_____

Signature of Parent/Guardian if a minor Date

Reviewed by _____ Date _____

Shepherds MINISTRIES