island health care island hospice THAGroup independent life at home ideal aging

VOLUNTEER HEALTH SCREENING EVALUATION

Name: _____ Date: _____

DOB: _____ Allergies: _____

General Health Survey

During the last 12 months, have you experienced pain, discomfort or pressure in your chest?	☐ YES ☐ NO
During the last 12 months, have you had difficulty breathing, shortness of breath, dizziness, fainting or blackouts?	☐ YES ☐ NO
Do you have pain in your joints or back that may interfere with your volunteer activities?	☐ YES ☐ NO
Has your physician told you to avoid contact with sick or immune compromised people?	☐ YES ☐ NO
Have you been diagnosed with an illness or condition that would cause a direct threat to the health or safety of others?	☐ YES ☐ NO
Are you aware of any health condition that could put you or the people you volunteer with at risk?	☐ YES ☐ NO

Tuberculosis Screening:

Have you ever had a positive PPD?	☐ YES ☐ NO
Have you ever taken medication for treatment of a positive PPD?	☐ YES ☐ NO
Has anyone living with you ever had TB or been treated for a positive PPD?	☐ YES ☐ NO
Have you ever had an allergic reaction to PPD?	☐ YES ☐ NO
Are you pregnant?	☐ YES ☐ NO

Do you or anyone you have contact with have any of the following symptoms?

☐ YES ☐ NO A cough lasting more than 2 weeks
☐ YES ☐ NO Chest pain
☐ YES ☐ NO Coughing up blood or phlegm
☐ YES ☐ NO Unusual weakness or fatigue
☐ YES ☐ NO Shortness of breath
☐ YES ☐ NO Loss of appetite
☐ YES ☐ NO Fever & chills
☐ YES ☐ NO Night sweats
☐ YES ☐ NO Unexpected weight loss

If unable to take PPD, date of last chest X-Ray: _____ Results: _____

A copy of X-Ray results must be provided.

PPD Test LOT #: _____ Expiration: _____

Administered on: _____ BY _____
[Date] *[Nurse]*

Anatomical Location: _____

Read on: _____ BY _____
[Date] *[Nurse]*

Results: ☐ Positive _____mm ☐ Negative

PPD Test LOT #: _____ Expiration: _____

Administered on: _____ BY _____
[Date] *[Nurse]*

Anatomical Location: _____

Read on: _____ BY _____
[Date] *[Nurse]*

Results: ☐ Positive _____mm ☐ Negative

☐ I affirm that the information I have provided is accurate to the best of my knowledge, and that I am able to perform the role of volunteer without putting my health and safety, or the health and safety of others, at risk.

_____ _____
Volunteer Signature *Date*

☐ Volunteer's health status report is satisfactory.
☐ Volunteer requires a physician's release to begin service.

_____ _____
RN Signature *Date*