Andrus on Hudson

ANDRUS ON HUDSON
VOLUNTEER HEALTH ASSESSMENT

Part I

Tuberculosis Screen – TO BE COMPLETED BY VOLUNTEER/PARENT/GUARDIAN

Volunteer Name:_____ **Dept.**_____

Have you recently been exposed to somebody with TB? Yes___No___ Don't Know___

MMR Titer Yes _____ (Date) _____ No ____ Immunization Date _____
Hepatitis B Titer Yes _____ (Date) _____ No ____ Immunization Date _____
(lab report required or immunization record)

- Do you have any of the following health conditions?
- Diabetes Mellitus Yes____ No ___
- Blood/Lymph Disease Yes ___ No___
- (i.e. Leukemia, Hodgkin's)
- Do you take Corticosteroids? Yes ___ No ___
- (i.e. Prednisone, Cortisone)
- Are you taking any immunosuppressive drugs? Yes ___ No ___
- (i.e. Azathioprine, Cyclosporine, Muromanab)
- Do you have any of the following symptoms?

CONDITION	NO	YES	IF YES, EXPLAIN
FEVER			
TIREDNESS			
WEAKNESS			
NIGHT SWEATS			
LOSS OF APPETITE			
UNEXPLAINED WEIGHT LOSS			
SWELLING NECK, ARMPIT OR GROIN			
COUGH WITH SPUTUM			
BLOOD TINGED SPUTUM			

VOLUNTEER_____**DATE**_____

PARENT/GUARDIAN _____ **DATE** _____

---- O V E R -----

Part II

Health Status – TO BE COMPLETED BY Volunteer/Parent/Guardian

Name _____Dept._____Birth Date_____

VOLUNTEER HEALTH HISTORY: Answer **Yes** or **No** to each item. **Explain Yes answers**.

Operations	Yes ____ No ____	Latex Allergy	Yes_____ No____
Fractures	Yes ____ No ____	Epilepsy	Yes ____ No ____
Head Injury	Yes ____ No ____	Mental Disease	Yes ____ No ____
Other Injuries	Yes ____ No ____	Jaundice	Yes ____ No ____
Chronic Back Pain	Yes ____ No ____	Rheumatism	Yes ____ No ____
Hypertension	Yes ____ No ____	Asthma	Yes ____ No ____
Stomach Problem	Yes ____ No ____	Diabetes	Yes ____ No ____
Hernia	Yes ____ No ____	Rubella (German Measles)	Yes ___ No ___
Skin Disease	Yes ____ No ____		

Hepatitis A_____ B _____ C_____ Other _____
Drug Allergies Yes ____ No ____ If Yes, type(s)_____
Allergies: _____

Do you have a habituation or addiction to alcohol, narcotics, depressants, stimulants, or any other drugs or substances? Yes ____ No ____ If Yes, Explain _____

Do you have a history of positive PPD? Yes_____ No_____

NOTE: This assessment is for the purpose of determining your health status for volunteering.
It is not to be considered a substitute for your total medical care by your physician.

I understand that any falsification or misrepresentation of medical facts will be sufficient grounds for my release from volunteering.

VOLUNTEER SIGNATURE_____ DATE_____
PARENT/GUARDIAN SIGNATURE _____DATE_____

PART III_____
TO BE COMPLETED BY HEALTH PERSONNEL

BP _____Height _____ Weight _____
Medications _____
Disabilities _____
Physician's determination re: TB screening: Mantoux PPD needed Yes ____ No ____
If yes, date PPD administered _____site _____Administered by _____
Date PPD read _____ Result _____ MM read by _____
Chest x-ray required Yes ____ No ____ If yes, reason ( ) PPD Conversion ( )
Symptomatology _____
Date of x-ray _____ Results_____
Evaluation/Follow up _____
Health Professional Name _____Signature _____Date _____