



**ST. LUKE'S EPISCOPAL HEALTH SYSTEM
EMPLOYEE HEALTH SERVICES
NEW VOLUNTEER HEALTH REVIEW**



Today's Date: _____ Volunteer Program: _____ Start Date: _____

Name _____ Age _____ Male _____ Female _____
 Last Name First Name Middle Name

Social Security # _____ Date of Birth _____ Home Phone # _____

Physician's Name _____ Physician's Phone Number _____

In case of Emergency, Notify _____ Relationship _____ Phone Number _____

Have you ever had any of the following (please circle answer):

Past History of Disease

Laboratory Testing
Indicating Immunity

Chicken Pox (Varicella)	Yes	No	Unknown	Yes	No	Unknown
Rubella (German Measles)	Yes	No	Unknown	Yes	No	Unknown
Rubeola (Red Measles)	Yes	No	Unknown	Yes	No	Unknown
Mumps	Yes	No	Unknown	Yes	No	Unknown
Polio	Yes	No	Unknown	Yes	No	Unknown

Immunization Records

Date of Last Immunization

Polio _____
 DPT (Diphtheria/Pertusis/Tetanus) _____
 Tetanus/Diphtheria Booster _____
 MMR (Measles/Mumps/Rubella) _____
 Measles Only _____
 Rubella Only _____
 Mumps Only _____

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Please List all prescription medications that you are currently taking:

Do you have any health concerns, which might limit your ability to perform your volunteer responsibilities? No Yes
 If yes, please explain:

Have you ever had or do you now have any of the conditions listed below? For all yes answers, list approximate date/year of treatment and explain treatment briefly.

	<u>No</u>	<u>Yes</u>	<u>Explanation of Answer</u>
Alcoholism	_____	_____	_____
Arthritis	_____	_____	_____
Asthma/Emphysema	_____	_____	_____
Back Trouble	_____	_____	_____
Breathing Difficulty	_____	_____	_____

(Over to complete information on other side of form)

Have you ever had or do you now have any of the conditions listed below? For all yes answers, list approximate date/year of treatment and explain treatment briefly.

	<u>No</u>	<u>Yes</u>	<u>Explanation of Answer</u>
Cancer	_____	_____	_____
Chest Pains	_____	_____	_____
Diabetes	_____	_____	_____
Drug Abuse	_____	_____	_____
Epilepsy/Seizures	_____	_____	_____
Fainting/Dizziness	_____	_____	_____
Hernia	_____	_____	_____
Hearing Problem	_____	_____	_____
Heart Disease	_____	_____	_____
Hepatitis	_____	_____	_____
High Blood Pressure	_____	_____	_____
High Cholesterol	_____	_____	_____
Knee/Foot/Ankle Problem	_____	_____	_____
Liver Disease	_____	_____	_____
Nervous Breakdown/ Psychiatric Illness or treatment	_____	_____	_____
Obesity (> 20 pounds overweight)	_____	_____	_____
Stroke	_____	_____	_____
Surgery	_____	_____	_____
Ulcers	_____	_____	_____
Vision Problem	_____	_____	_____
Other	_____	_____	_____

I hereby declare that my answers to the above questions are complete and true. I agree that any false statement shall be sufficient cause for dismissal. I hereby grant permission to St. Luke's Episcopal Health System to investigate any information included in this form, and to contact my personal physician (listed on page 1 of this form) with regard to the information given. I understand that any information given to St. Luke's Episcopal Health System by myself or my physician will remain confidential.

Signature of Volunteer _____ Date _____

For Volunteers Less than 18 Years of age the signature of a parent or legal guardian is required:

Signature of Parent/Guardian _____ Date _____

Printed Name of Parent/Guardian: _____ Day Time Phone Parent or Guardian _____

To be filled out by EMPLOYEE HEALTH:

Height: _____ Weight: _____ B/P: _____ Pulse: _____ Temperature: _____

Date PPD Placed: ___/___/___ Rt/Lt forearm: _____ Nurse Initials: _____

Date PPD Read: ___/___/___ Size: 0mm or _____mm x _____mm Result: Positive/Negative _____ Nurse's Initials: _____

Chest X-Ray: Date Ordered/Initials: _____ Date Results/Initials: _____

Comments/Other: _____

Employee Health Nurse

Date