University Hospitals
Volunteer Services

VOLUNTEER HEALTH SCREENING FORM

Volunteer Name:_____ Birthdate (mm/dd/yyyy): ____/____/____

To be completed by your Health Care Provider. Please do not send immunization records.

If not completed by your healthcare provider, this form will not be accepted.

INFLUENZA (required annually if volunteering during flu season October-April)

- Date given:_____; or attach proof of flu vaccine

TUBERCULOSIS (TB)

- Date of last TB screening: _____ If unknown, a 2-step TB screening is required.

Please review the questions below. *Check only those to which the answer is YES:*

- ☐ I have been a temporary or permanent residence of ≥1 month in a country with a high TB rate (Any country other than the United States, Canada, Australia, New Zealand, and those in Northern Europe or Western Europe) since my last TB test.
- ☐ I am currently or will be immunosuppressed [this includes those with HIV infection, recipients of organ transplants, treatment with a TNF-alpha antagonist (e.g., infliximab, etanercept, or other), chronic steroids (equivalent of prednisone ≥15 mg/day for ≥1 month) or other immunosuppressive medication]
- ☐ I have been in close contact with someone who has had infectious TB disease since my last TB test.
- ☐ I currently have symptoms of TB (a cough lasting longer than three weeks, unexplained weight loss, night sweats or a fever).
- ☐ I will be volunteering more than 150 hours in a year with UHHS.

If the answer to all of the above questions is no, additional TB testing is not required. If any of the answers are yes, one of the following tests are required within the last year. If either of the following tests are positive, attach provider clearance note that indicates volunteer is free of active TB infection as demonstrated on Chest X-Ray.

- TB Skin Test (Please note that a TB skin test requires 4 visits to complete.)
  - Date of read #1:_____ _____mm P N
  - Date of read #2:_____ _____mm P N
- Serum TB test (Quantiferon Gold, TSpot)
  - Date:_____ Result:_____

FOR THOSE VOLUNTEERING IN PEDIATRICS, NEWBORN & LABOR & DELIVERY UNITS

CHICKEN POX (one of the following is required)

- Two doses of varicella vaccine. Date given: dose #1:_____ dose #2:_____
- History of disease. Date:_____
- Proof of immunity. Titer date:_____ Result:_____

MMR (one of the following is required)

- Two doses of MMR vaccine. Date given: dose #1:_____ dose #2:_____
- Proof of immunity. Titer date:_____ Result:_____

TDAP (one dose in adulthood)

- Date given:_____

HEPATITIS B (one of the following is required)

- Completion of a full vaccine series of Hepatitis B (2 or 3 vaccine series accepted)
- Date given: dose #1:_____ dose #2:_____ dose #3 (if indicated):_____
- Proof of immunity. Titer date:_____ Result:_____

Healthcare Provider Confirmation

I confirm that I have reviewed that the information provided by the individual above is correct and I know of no medical reason this individual should not be allowed to volunteer at a UHHS facility.

Clinician name (printed) Clinician signature Date

Office stamp including address and phone number