Sacred Heart Health System

Medical Record:

Volunteers, Students, Temporary Employees, Contract Employees

NAME _____ SOCIAL SECURITY NO. _____

ADDRESS _____ TELEPHONE _____

_____

HEIGHT _____ WEIGHT _____ DATE OF BIRTH _____

Do you have a history of: Rubella _____ Chickenpox _____

Tuberculosis _____ Chronic Cough _____

Rash _____

PRIMARY CARE PHYSICIAN OR FAMILY DOCTOR _____

ARE YOU TAKING ANY MEDICATION? _____

REMARKS _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

PARENT OR GUARDIAN: Please provide a copy of your Measles-Rubella Immunization. You must have documentation of 2 MMR's. Please indicate by your signature your consent to allow your child to have a **Measles-Rubella immunization** if indicated and a **TUBERCULOSIS SKIN TEST (PPD) ANNUALLY.**

DATE: _____ **SIGNATURE:** _____