Ascension

Ascension WI North Region

NEW VOLUNTEER ASSESSMENT

Name:____ Birthdate:____________________ Sex: _________

Phone Number:______________ Address: ____

City / State: ____ Zip Code: ______________

Location: ***Please check the location where you will be volunteering***

☐ Saint Michael's ☐ Saint Clare's ☐ Good Samaritan ☐ HYMC ☐ ERMH ☐ St. Mary's ☐Sacred Heart ☐ Mercy ☐ St. Elizabeth Hospital ☐ CMC

Immunization History:

Have you been fully immunized against the following:

	Yes	No
Diphtheria (3 doses DPT)	☐	☐
Pertussis (Whooping Cough) (3 doses DPT)	☐	☐
Tetanus Booster, Year________	☐	☐
Polio	☐	☐
Measles	☐	☐
Mumps	☐	☐
Rubella	☐	☐
Small Pox	☐	☐
Varicella (Chicken Pox)	☐	☐
Did you experience any adverse reactions to any of the above:	☐	☐

Do you have or have you ever had any of the following:

	Yes	No
Drainage or discharge from the eyes, ears or nose:	☐	☐
Hepatitis A	☐	☐
Hepatitis B	☐	☐
Hepatitis C	☐	☐
Polio	☐	☐
Malaria	☐	☐
Rubella (German Measles)	☐	☐
Rubeola (Measles)	☐	☐
Chicken Pox	☐	☐
Mumps	☐	☐
Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Any other infectious disease, other than colds/flu?	☐	☐

____

TB Screening:

Please answer the following questions so Associate Health can determine if you need a TB skin test. If you would rather have a TB skin test instead of answering the questions, please indicate by checking this box: ☐

		YES	NO
1.	Do you have a requirement for an annual TB test at another facility outside of the Ascension WI system? If yes, please provide results.	☐	☐
2.	Do you currently have:		
	a. Persistent productive cough (greater than 2 weeks duration unrelated to another diagnosis)	☐	☐
	b. Night sweats (unrelated to menopause)	☐	☐
	c. Unexplained weight loss	☐	☐
	d. Coughing up blood	☐	☐
	e. Loss of appetite	☐	☐
	f. Fever – with unknown cause	☐	☐
3.	To your knowledge, during the course of this past year, have you provided medical care, or become exposed to a patient with known active TB? If yes, explain ____	☐	☐
4.	To your knowledge, have you had an exposure to a known active TB patient in the community setting or at home this past year (i.e., a relative, friend, or other contact)? If yes, explain ____________________________________	☐	☐
5.	Have you had a positive TST or positive Q-Gold test in the past? If yes, when: ____________	☐	☐
6.	Have you done any travel outside of the U.S. and/or Canada for greater than a total of 60 days in the last year? If yes, where ______________________. What date did you return to the U.S. ________________	☐	☐
7.	Have you volunteered in another health care facility outside of the Ascension WI system?	☐	☐
8.	Have you performed missionary work in the last year, either in or out of the U.S.?	☐	☐
9.	Were you on military/leave duty in the last year?	☐	☐

**Be certain to contact the Hospital Associate Health Office if you ever have an exposure to a known active TB patient, or you develop any of the above symptoms or concerns during the course of your volunteering.

Signature: ____ **Date:** _________________________

TO BE COMPLETED BY PARENT OR GUARDIAN: (If under 18 years of age)

I hereby consent to my child serving as a volunteer at Ministry Health Care. I also give permission for health screening tests: A urine drug screen, a Tuberculin skin test, and blood test for Measles, Rubella, Chicken Pox, and Mumps immunity, to be done in the Hospital's Associate Health Office. I may be contacted by the Medical Review Officer to clarify any non-negative drug screen. I understand, if he/she is not immune to any of the above tests, it will be my responsibility to see that he/she gets the immunization before being assigned.

Signature Parent or Guardian: _____________________________________**Contact Phone #:** ____________________________**Date:**_________