Volunteer Health Form

Name of Applicant: _____ Date_____

Physician: _____ Physician's Phone _____

Physician's Address: _____

_____

_____

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Dear Doctor or Health Service Provider:

The above mentioned has applied to provide volunteer services at Clara's House. The work may include patient contact.

IN COMPLIANCE WITH THE CALIFORNIA STATE HEALTH CODE, VOLUNTEERS MUST HAVE A RECORDED MEDICAL HISTORY AND PHYSICAL EXMINATION PRIOR TO WORKING. WE WOULD APPRECIATE YOUR FILLING OUT THE FOLLOWING QUESTIONS.

Applicant's full name_____ Date of Birth _____

The applicant is in general good health and is free from communicable disease? __Yes __No

If no, please explain:

_____

List any restrictions:

_____

TB skin test date/results: _____
(must be within last 3 months)

Two MMR inoculations are required for anyone born since January 1, 1957. If two MMR inoculations were not given, please provide other proof of immunity.

Date of first MMR: _____ (after 12 months of age)

Date of second MMR: _____

Other proof of immunity: _____

Date of last Diphtheria-Tetanus (must be within last 10 years): _____

Applicant has had CHICKENPOX? _____Yes _____No _____Unknown

If you are a Health Care Provider have you had a Hepatitis shot? _____Yes_____No

We would appreciate your returning this form as soon as possible as volunteers may not begin until this form is completed. All responses will be treated in strict confidence.

The applicant's signature below represents permission for you to provide us with the above information.

_____ Date: _____
Applicant's Signature

_____ Date: _____
Physician's Signature

Thank you very much!

Please return form to:

Clara's House
2715 K Street, Suite D
Sacramento, CA 95829
FAX 916-266-9320
Ph 916-448-3976