

### VOLUNTEER HEALTH RECORD

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

GENDER: F M SOCIAL SECURITY NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_  
(Street) (City) (State) (Zip)

HOME PHONE: \_\_\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ PHONE #: \_\_\_\_\_

1. Have you had a viral vaccine such as Measles (Rubella), German Measles (Rubeola) or Mumps in the last 6 weeks?  
\_\_\_\_\_ If yes, date? \_\_\_\_\_
2. Have you had a TB (tuberculosis) skin test in the past? \_\_\_\_\_ If yes, date? \_\_\_\_\_  
Results: \_\_\_\_\_ Where did you receive it? \_\_\_\_\_
3. Have you ever had BCG? (Medication to prevent TB) \_\_\_\_\_
4. Have you ever had an allergic reaction to a TB skin test? \_\_\_\_\_
5. Date and result of last chest x-ray (if ever): \_\_\_\_\_
6. Have you had INH treatment (Medication to treat TB)? \_\_\_\_\_ If yes, date? \_\_\_\_\_
7. Do you have any restrictions from a past or present health condition that Occupational Health should be aware of?  
 Yes  No  
If yes, please explain: \_\_\_\_\_

8. Childhood Illnesses or Vaccinations (Please indicate dates):

Immunization	Date of Dose # 1	Date of Dose # 2	Date of Dose # 3
MMR (Measles, Mumps, Rubella)			
Hepatitis B Vaccine			
Varicella Vaccine*			

\*If your child did not have two Varicella Vaccines, a History of Chicken Pox disease is required.

My child has had the Chicken Pox disease in: \_\_\_\_\_  
(Year)

I have reviewed the above statements and I certify that the information is true to the best of my knowledge. I give permission for my child, the above named, to have a Quantiferon Gold TB blood test (\*screening test for past exposure to tuberculosis).

Date: \_\_\_\_\_ Signature: \_\_\_\_\_  
(Parent/Guardian if under 18 years of age)

For Clinic Use Only:  
Quantiferon Gold Test: Date: \_\_\_\_\_ Result: \_\_\_\_\_