

VOLUNTEEN 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: _____