



## NEW VOLUNTEER ASSESSMENT

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Address: \_\_\_\_\_

City / State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

*Please indicate where at Marshfield Clinic Health System you will be volunteering:*

### Immunization History:

**Have you been fully immunized against the following:**

	<u>Yes</u>	<u>No</u>
Diphtheria (3 doses DPT)	<input type="checkbox"/>	<input type="checkbox"/>
Pertussis (Whooping Cough) (3 doses DPT)	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus Booster, Year _____	<input type="checkbox"/>	<input type="checkbox"/>
Polio	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Rubella	<input type="checkbox"/>	<input type="checkbox"/>
Small Pox	<input type="checkbox"/>	<input type="checkbox"/>
Varicella (Chicken Pox)	<input type="checkbox"/>	<input type="checkbox"/>
Did you experience any adverse reactions to any of the above:	<input type="checkbox"/>	<input type="checkbox"/>

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

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

### TB Screening:

**Please answer the following questions so Employee 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:**

	<u>YES</u>	<u>NO</u>
1. Do you have a requirement for an <u>annual</u> TB test at another facility outside of the Marshfield Clinic Health Systems? If yes, please provide results.	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you currently have:		
a. Persistent productive cough (greater than 2 weeks duration unrelated to another diagnosis)	<input type="checkbox"/>	<input type="checkbox"/>
b. Night sweats (unrelated to menopause)	<input type="checkbox"/>	<input type="checkbox"/>
c. Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>
d. Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
e. Loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>
f. Fever – with unknown cause	<input type="checkbox"/>	<input type="checkbox"/>
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 _____	<input type="checkbox"/>	<input type="checkbox"/>
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 _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you had a positive TST or positive Q-Gold/T-spot test in the past? If yes, when: _____	<input type="checkbox"/>	<input type="checkbox"/>
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. _____	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you performed missionary work in the last year, either in or out of the U.S.?	<input type="checkbox"/>	<input type="checkbox"/>
8. Were you on military/leave duty in the last year?	<input type="checkbox"/>	<input type="checkbox"/>

**\*\*Be certain to contact the Hospital Employee 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:** \_\_\_\_\_