**HEALTH ASSESSMENT FORM FOR VOLUNTEERS/STUDENTS/INTERNS**

**Name (Print): \_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_ Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Welcome to St Barnabas Health System. In order to complete your screening for your temporary position in the hospital, please have your doctor/clinic provide all of the following Department of Health requirements.

**PROVIDER:** Fill out form completely. Provide dates and results of each test and **ATTACH ALL COPIES OF LAB WORK TO THIS MEDICAL FORM.**

**PPD/Quantiferon Date: Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**If positive, Chest X-Ray within 1 year Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Rubella Titer Date: Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Measles Titer Date: Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Mumps Titer Date: Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Varicella Titer Date: Result: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Or (2) Varicella Vaccine(s) Date: Date: \_\_\_\_**

**Hepatitis B**

**Antibody (Hep B Surface Antibody) Date: Antibody Result: \_\_\_\_\_\_\_\_\_\_\_**

**Antigen (Hep B Surface Antigen) Date: Antigen Result: \_\_\_\_\_\_\_\_\_\_\_\_­­­­­­­\_**

**Core Antibody (HB Core Antibody) Date: Core Antibody Result: \_\_\_\_**

**Last Tdap (Must be within 10 years) Date:**

**Influenza vaccine**

**Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_ Manufacturer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Lot number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Expiration Date: \_\_\_­ \_\_\_\_\_ \_\_\_\_\_ Reactions, if any: \_\_­ \_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s Certification**: I have examined the above named patient. The patient is free of any health impairment which may pose potential risk to others and/or which might interfere with the patient’s performance.

Examining Physician’s Signature **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Date**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Examining Physician’s Name (Print) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Examining Physician’s Medical License Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Examining Physician’s Telephone Number**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**