CENTENNIAL MEDICAL CENTER
TEEN VOLUNTEER- ANNUAL HEALTH INFORMATION

****PLEASE COMPLETE ALL THREE SECTIONS AND SIGN ON THE BOTTOM OF PAGE****

Employee Name: _____ Home Phone: _____
Department: ___Volunteer Services____ Soc. Sec. Number: (last 4 digits) _____

SECTION 1: TB SCREENING

Past Positive PPD (TB Skin Test): NO ____ YES _____ (see back) Pregnant? (see back)

PPD Skin Test 0.1cc ID in arm: (Must be read by RN or MD between **48-72 hours** of administration)

Date given: _____ RN or MD signature: _____
Date read: _____ RN or MD signature: _____

Results: NEGATIVE _____ SIZE _0_mm POSITIVE* _____ SIZE ____mm

***POSITIVE TB SKIN TEST THIS TIME? EMPLOYEE MUST FOLLOW UP WITH THE EMPLOYEE HEALTH NURSE AT 342- 4818**

SECTION 2:

PARENTAL / GUARDIAN PERMISSION FOR TB TESTING

Teen Volunteer's Name _____
Last First Middle Initial

Birth date _____- _____- _____
Month Day Year

Centennial Medical Center requires that all employees and volunteers have an annual TB skin test. To fulfill this requirement:

_____ I have attached a copy of my son/ daughter's TB skin test results performed within the past year.

_____ I give my permission for my son/ daughter, _____, to receive a TB skin test at Centennial Medical Center. I understand that he/ she will need to return two days later to have the results read by the Employee Health or Emergency nursing staff.

PARENT/ GUARDIAN SIGNATURE: _____DATE_____

CENTENNIAL MEDICAL CENTER-Teen Application cont.
QUESTIONNAIRE FOR SIGNS/SYMPTOMS OF TUBERCULOSIS

I am unable to take the annual TB skin test because:

_____ I am pregnant

_____ I have a history of a past positive Tuberculin skin test

_____ I have a history of BCG vaccination

_____ I am allergic to the preservative found in the Tuberculin skin test

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Check YES or NO for the following signs and symptoms of active tuberculosis:

Easy fatigue (Tire easily)	YES ____	NO ____
Anorexia (Decreased appetite)	YES ____	NO ____
Weight loss	YES ____	NO ____
Fever	YES ____	NO ____
Night sweats	YES ____	NO ____
Chronic cough (lasting more than three weeks)	YES ____	NO ____
Sputum production (Cough up phlegm)	YES ____	NO ____

If yes, what does it look like? _____

Hemoptysis (Blood in sputum)	YES ____	NO ____
Chest pain	YES ____	NO ____
Dyspnea (Shortness of breath)	YES ____	NO ____
Significant exposure to someone with active tuberculosis in the past year	YES ____	NO ____

_____ _____ _____
Print Name Signature Date

_____ _____
Department Social Security Number (last 4 digits)

If you have questions, contact Employee Health/ Pamela Garrett at 342-4822