Volunteer Health Clearance Form

Please fill out form completely and return with all required immunization records to your volunteer coordinator. Any questions in regards to completion of this form, please contact Employee Occupational Health at 612-262-4490.

****Your social security number is required to process health clearance in the Allina Health System****

Name:____ SSN# (required):________________________Date of Birth:_______________

Phone Number (daytime): _____________________________________Email:____

Volunteer Site: _________________________________ Places you have lived outside USA: _______________________________________

PLEASE READ THROUGH ALL THE FOLLOWING QUESTIONS.
CHECK ALL ANSWERS THAT APPLY TO YOU.

Tuberculosis (TB)

_____ I have never had a skin test or blood test for TB (Mantoux)
_____ I have had a negative skin test for TB
_____ Approximate date of last test (month and year) ____
_____ I have received BCG vaccine (uncommon in U.S.)
_____ I have had a positive skin test or blood test for TB
  _____ not treated _____ treated with isoniazid (INH) or other medication
  Dates of treatment: ________________ Duration of treatment________________________________
_____ I have had TB
_____ I have had a reaction (e.g. redness, swelling or bump) to TB skin test. If yes, describe:
____

Current Health Status – Any current symptoms such as

____fever____cough over 3 weeks_____bloody sputum_____night sweats____weight loss____fatigue____poor appetite____unexplained chills ____chest pain

____No current symptoms

Mumps

_____ I have had two Mumps vaccines. If yes, have documentation that you had it yes ☐ no ☐
_____ I have been tested for Mumps antibody. Date ___________________
  Was test: positive ☐ negative ☐ don't know ☐
_____ I don't know if I have had Mumps or been vaccinated

Rubella (German Measles)

_____ I had rubella vaccine. If yes, have documentation that you had it? yes ☐ no ☐
_____ I have been tested for rubella antibody. Date ___________________
  Was test: positive ☐ negative ☐ don't know ☐
_____ I don't know if I have had German measles or been vaccinated

Measles (Rubeola) (Red Measles)

_____ I have had Measles vaccine. If yes, have documentation that you had it yes ☐ no ☐
_____ I have been tested for rubeola antibody. Date ___________________
  Was test: positive ☐ negative ☐ don't know ☐
_____ I don't know if I have had Measles (Rubeola) or been vaccinated

Chickenpox

_____ I have had chickenpox (Varicella) vaccine.
If yes, do you have documentation of two vaccinations? yes ☐ no ☐
_____ I have been tested for chickenpox immunity.
If yes, do you have documentation of lab titer results? yes ☐ no ☐
_____ I don't know if I have had Chickenpox/and or shingles or been vaccinated

Tetanus / Diphtheria / Pertussis

_____ I had a primary series of 3 or 4 doses of DT, DPT, Td, or Tetanus vaccine
_________ Date of last tetanus vaccine "booster"
_________ Date of last documented DPT vaccine
____ I had a single adult does of Tdap vaccine
_________ Date of documented Tdap vaccine
_____ Allergy
_____ Unknown

Hepatitis B (required only if your assignments have the potential for blood & body fluid exposure)

_____ I have had Hepatitis B. If yes, date ______________.
_____ I have had the Hepatitis B vaccine. If yes, approximate dates:
Dose 1 __________ Dose 2 __________ Dose 3 __________ Dose 4 __________
Other (describe) ____
_____ I have been tested for Hepatitis B antibody. If yes, date _____________.
Where tested ____
Was test: positive ☐ negative ☐ don't know ☐
_____ I have had Hepatitis B surface antigen test. If yes, date ______________.
Was test: positive ☐ negative ☐ don't know ☐
_____ I don't know if I have had Hepatitis or been vaccinated.

COVID Vaccine

______ I have NOT had the COVID vaccine.

______ I have had the COVID vaccine. If yes, dates

Date of dose 1:___________ Manufacturer______________________

Date of dose 2:___________ Manufacturer______________________

Date of dose 3:___________ Manufacturer______________________

Influenza Vaccine

______ I have NOT had the Influenza vaccine.

______ I have had the Influenza vaccine. If yes, dates

Date:_______________
Location received:______________________

Immune Status: People with weakened immunity are at risk for more serious disease due to infection and may also pass infection more easily to others. Check if you have had the following:

______ Splenectomy (spleen removed)
______ Organ transplant
______ Chronic steroid use (taking Cortisone, Prednisone, etc.). If yes:
Name of medication(s) and dose ____
How long have you been on these medications? ____
______ Chemotherapy or radiation
______ Immune deficiency disease: lymphoma ☐ leukemia ☐ HIV infection ☐
Other malignancy or condition (list)____

CONSENT:

VOLUNTEER NAME (Please Print): ____

VOLUNTER SIGNATURE ____ DATE: ______________________

☐ By checking this box, I consent for a detailed voicemail to be left in regards to any type of follow up needed.

PARENTAL CONSENT **required if applicant under 18 years old:**

____ DATE: ______________________
(*Parent/guardian signature*)

By signing above, you are consenting to have your child receive the necessary lab tests and/or immunizations in order to be cleared to work as a volunteer.

VOLUNTEERS please provide copies of all prior immunization records and/or lab titers listed below if you have available to you:

- **COVID**
- **Influenza**
- **TB skin test or QFT (TB blood test)**
- **Chest x-ray only if positive TB history**
- **MMR (Measles, Mumps, Rubella)**
- **Hepatitis B**
- **Tdap or TD**
- **Chicken Pox (Varicella)**

Choose the lab you would like to go to. **Wait 3 days to allow your order to be received and set up**. You can report to the lab within 3 to 14 business days after you submit your request. **Please note, all lab tests in which are ordered are FREE of charge. If not contacted by EOH follow the 3 day directions.**

Blood tests that may be ordered are:

1. **Tuberculosis screening (QFT-Quantiferon Gold Test)**
2. **Immunity assessment to Measles, Mumps, Rubella, and Chicken Pox (varicella)**

See next page to select your desired lab location:

Location	Hours	Address
Abbott North Western Hosp. (Minneapolis)	6am-6pm M-F 7am-1:30pm Sat	800 East 28th St Minneapolis, MN 55407
Abbott Northwestern Center for Out Patient Care EDINA	8am-5pm **Call For Appointment** 952-914-8046	8100 W. 78th St Suite 110 Edina, MN 55439
Buffalo Hospital	7am-3pm M-F **Call For Appointment** 763-684-7855	303 Caitlin St Buffalo, MN 55313
Cambridge Medical Center	7am-3pm M-F	701 South Dellwood St Cambridge, MN 55008
Faribault Allina Health Clinic	7:30am-4:00pm M-F	100 State Ave Faribault, MN 55021
Hastings Allina Health Clinic	8am-3:30pm M-F	1880 N. Frontage Road Hastings, MN 55033
Mercy Hospital (Coon Rapids)	6am-6pm M-F 7am-1:30pm Sat	4050 Coon Rapids Blvd Coon Rapids, MN 55433
New Ulm	8am-5pm M-F **Call For Appointment** 507-217-5366	1324 Fifth North St New Ulm, MN 56073
Northfield Allina Health Clinic	8am-5pm M-F	1400 Jefferson Rd Northfield, MN 55057
Owatonna Hospital	8am-2pm M-F Report to Emergency Room Registration Desk	2250 NW 26th St Owatonna, MN 55060
River Falls Hospital	6:30am-2:30pm M-F	1629 E. Division St River Falls, WI 54022
St. Francis Hospital (Shakopee)	9:30am-4pm M-F	1455 St. Francis Ave Shakopee, MN 55379
Mercy Hospital—Unity Campus (Fridley)	6am-6pm M-F 7am-1:30pm Sat	550 Osborne Rd Fridley, MN 55432
United Hospital (St. Paul)	6am-6pm M-F	333 North Smith Ave St. Paul, MN 55102
West Health (Plymouth)	7:30am-4pm M-TH 7:30am-2pm F	2855 Campus Dr Suite 215 Plymouth, MN 55441