Volunteer Program Health Form

Name: ____ Date of Birth: ______________

Address:____ Telephone: _________________

I authorize my medical information from ____to be released to MedWorks, Bristols Healths Occupational Health Clinic.

____ Date: _____________________
Volunteer or Legal Guardian Signature

The above named individual has applied to become a volunteer at Bristol Health and is required to obtain a medical health screening. Please complete this form and fax/mail it to MedWorks, 975 Farmington Avenue, Bristol CT 06010. **Fax: 860-589-1936.** All information is kept confidential.

To Be Completed by Physician/APRN

Healthcare statements:

1) There is no evidence of communicable diseases at the time of this evaluation. Yes No
i. circle one

2) This applicant can work directly with patients. Yes No
circle one

3) This applicant is in good health to volunteer. Yes No
circle one

Additional comments:
____
____

Immunizations/Vaccines	Date(s) Received
Varicella (chickenpox)	
Measles/Mumps/Rubella (MMR)	
PPD/ TB Screening	Date Planted:________ Date Read:_________ Results in mm:__________________________
Hep B Injections or Date Declined	__________ __________ ___________

Proof of COVID vaccine(s) & boosters	Please attach copy
Seasonal flu vaccine	
Tetanus/DPT (if applicable)	

____ ______________________________________

Physician, APRN -Please Print Physician, APRN Signature

____ ____________________________________

Address Office Telephone Number

Revised 8/2022 kh
Cc Medworks