RUSK COUNTY MEMORIAL HOSPITAL AND NURSING HOME
LADYSMITH, WI 54848

VOLUNTEER/VOLUNTEEN HEALTH CERTIFICATE

PART A – TO BE COMPLETED BY VOLUNTEER/VOLUNTEEN

NAME: ______________________________________ **SS #**_________________ **DOB:**___________

VOLUNTEER/VOLUNTEEN'S ADDRESS: ____

____

NOTIFY IN CASE OF EMERGENCY: ___________________________ **RELATIONSHIP:** ____________

ADDRESS OF EMERGENCY CONTACT: _____________________________ **PHONE:** _______________

NAME OF FAMILY PHYSICIAN: ____________________________________ **PHONE:** _______________

HEALTH HISTORY

Do you currently have, or have you experienced, any of the following conditions:

Yes	No	**Chest**
☐	☐	Persistent Cough
☐	☐	Wheezing
☐	☐	Asthma
☐	☐	Bronchitis
☐	☐	Pneumonia
Yes	**No**	**Throat**
☐	☐	Difficulty Swallowing
☐	☐	Hoarseness
Yes	**No**	**Circulation**
☐	☐	Heart problems
☐	☐	Tightness/chest pain
☐	☐	Blood pressure problems
☐	☐	Frequent nose bleeds
☐	☐	Dizzy spells
☐	☐	Varicose veins
☐	☐	Numbness of hands/feet

Yes	No	**Communicable Disease**
☐	☐	Tuberculosis
☐	☐	Chicken pox
☐	☐	Hepatitis
☐	☐	Measles
☐	☐	Mumps
☐	☐	Rheumatic/scarlet fever
Yes	**No**	**Kidney/bladder**
☐	☐	Kidney/bladder infections
☐	☐	Kidney/bladder operations
Yes	**No**	**Sensory**
☐	☐	Hearing Impaired
☐	☐	Color blind
☐	☐	Poor sense of smell
Yes	**No**	**Skin**
☐	☐	Rashes/sores
☐	☐	Itching/burning skin

☐	☐	Bruise easily
☐	☐	Jaundice
Yes	**No**	**Muscle/skeleton**
☐	☐	Back pain
☐	☐	Swollen joints
☐	☐	Neck pain
☐	☐	Rheumatism/arthritis
☐	☐	Foot trouble
☐	☐	Hand/wrist problems
☐	☐	Knee problems
☐	☐	Operations
Yes	**No**	**Miscellaneous**
☐	☐	Epilepsy
☐	☐	Diabetes

Immunization Record: (last dates)
Chicken pox_________MMR________
Tetanus/Diptheria__________________
Hepatitis B (1)____________________
Hepatitis B (2)_________(3)________

Do you have any allergies? ☐ No ☐ Yes *If yes, to what*: ____

Have you had prior occupational exposures to chemicals and/or cleaning solvents that caused skin sensitivity, an allergic reaction, breathing difficulties, nausea, headaches and/or nosebleed? ☐ No ☐ Yes *If yes, explain:*

____

I AUTHORIZE MARSHFIELD CLINIC TO DISCLOSE MEDICAL INFORMATION TO RUSK COUNTY MEMORIAL HOSPITAL AND NURSING HOME.

I have read the above and have no injury, illness or ailment other than as specifically herein noted. I understand that any falsification, concealment or misrepresentation will result in denial of my volunteer privileges. Signature: _________________________________ Date: _______________

PART B – TO BE COMPLETED BY HOSPITAL LAB

Rubella Immunity: _______Date: _________ Varicella Zoster Immunity:_________Date:________________

(Completed Hepatitis C, Hgb, WBC, Macro Ua and Urine Drug Forms Attached)

Tuberculin Skin Test: Date Given: __________ Given By: ____________

Tuberculin Skin Test: Date Read: __________ Read By: ____________

(With Physician Order, hospital will provide a chest x-ray if volunteer/volunteen is a known positive).

Comments: ____

PART C – TO BE COMPLETED BY PHYSICIAN

Chest X-ray needed: ☐ NO ☐ YES

Date Chest X-ray scheduled: _________________ X-ray results:___________Read by: ________

Blood Pressure: _______________ Height: _________ Weight: ___________

Evidence of past or present communicable disease? ☐ No ☐ Yes (Explain)

____

____

Evidence of past or present musculoskeletal problems? ☐ No ☐ Yes (Explain)

____

____

PHYSICIAN RECOMMENDATIONS: (Please select one)

☐ **Qualified for the position of: Volunteer Volunteen (please circle one)**

☐ **Temporary disqualification or restriction due to temporary or correctable condition, or pending receipt of medical records: ____.**

☐ **Qualified for the position with the following restrictions: _____________________________________**

☐ **Permanent restrictions: ____**

☐ **Pre-existing disability rating: _______% for____**

______________________________________ ________________________

Signature of Examining Physician Date

Form #
11/07/07