



Sarah Neuman

THE NEW JEWISH HOME/SARAH NEUMAN HEALTH STATUS REPORT

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ Apartment: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_ Business # \_\_\_\_\_

Have you volunteered for the Jewish Home & Hospital Lifecare System before?  Yes  No

Do you have any physical or medical disabilities? Yes: \_\_\_\_ No: \_\_\_\_

If yes, please specify: \_\_\_\_\_

Notify in case of emergency: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Personal History: (Please check)

Immunization History: (Please check)

Table with 3 columns: Condition, Yes, No. Rows include Asthma, Allergies, Back Injury, Diabetes, Epilepsy, Fainting Spells, Heart Disease, High Blood Pressure, Psychiatric History, Visual Problems.

Table with 3 columns: Immunization, Yes, No. Rows include Chicken Pox, MMR, TB-TST (Manatoux), History of BCG (TB inoculation as a child in a foreign country).

To protect the health and well-being of our residents, Sarah Neuman requires proof of a current negative TST/Mantoux test for Tuberculosis (or negative chest x-ray), and proof of MMR immunization from all volunteers. New volunteers are required to have two PPDs (within two weeks of each other) before they can begin their assignments. In lieu of the two step TB test, volunteers may opt to have their doctor administer the QuantiFERON®-TB Gold test (QFT-G) blood test.

1st TST Lot # \_\_\_\_\_ Date of Exp. \_\_\_\_\_ Left Arm \_\_\_\_\_ Right \_\_\_\_\_

2nd TST Lot # \_\_\_\_\_ Date of Exp. \_\_\_\_\_ Left Arm \_\_\_\_\_ Right \_\_\_\_\_

Form with four columns: TST (skin test for TB), 2nd TST, Chest x-ray (If indicated), MMR: (Measles & Rubella) Proof of inoculation must be attached in order to be considered valid. Results must come from the doctor/facility that completed the inoculation and must include the date(s) administered. Includes checkboxes for Vaccination and Immune Titer.

**FOR DOCTORS USE ONLY: (If you are using your personal physician)**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Dear Physician or Health Center,

The above named person is in the process of applying as a volunteer at The Jewish Home & Hospital Lifecare System's Westchester Division, Sarah Neuman Center for Healthcare & Rehabilitation. Volunteers provide socialization, escort and/or wheel chair transport to activities, clinics and therapies, and assist with activities, orderliness or individual living space, grooming, and feeding and/or may work in offices providing clerical support.

In order to protect the health and well being of residents, patients, clients, staff, volunteers, and visitors at the facility, it is our policy and a recommendation of the NYDOH that all incoming volunteers have a two-step test for tuberculosis prior to working with our resident population. This test would require that anyone seeking work as a volunteer or intern must provide proof of having had two current negative TST/Mantoux tests for Tuberculosis (or negative chest x-ray) within ten days to two weeks of each other. If this is not completed, volunteers will **NOT** be permitted to work. Volunteers must also provide proof of measles immunization (if born after 1/1/57), proof of rubella immunization or immune rubella titer, and a statement of good health are required for anyone seeking access to the Jewish Home & Hospital as a volunteer.

**To Be Completed by Physician or Nurse Practitioners**

I certify that the above volunteer is in good health and medically able to perform his/her volunteer duties.

\_\_\_\_\_  
DOCTOR/NURSE SIGNATURE

\_\_\_\_\_  
DATE

Stamp Here

\_\_\_\_\_  
OFFICE ADDRESS

\_\_\_\_\_  
CITY

\_\_\_\_\_  
STATE

\_\_\_\_\_  
ZIP

**FOR PARENTS USE ONLY:**

I give permission to allow my child to volunteer at JHL. I am also authorizing JHL or the above doctor/nurse practitioners to administer the TST for Tuberculosis required by NY State law when volunteering in a nursing home. This test must be read within 48-72 hours by a medical professional after it is administered. If you have any questions please call the volunteer office at (914) 864-5140 for Westchester.

\_\_\_\_\_  
PARENT'S SIGNATURE

\_\_\_\_\_  
DATE

**FOR JEWISH HOME & HOSPITAL USE ONLY:**

**VOLUNTEER HEALTH CLEARANCE:**

CLEARED TO VOLUNTEER

NOT CLEARED TO VOLUNTEER

\_\_\_\_\_  
SIGNATURE OF MEDICAL CLINIC NURSE

\_\_\_\_\_  
DATE

**SPECIAL NOTES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_