PAGE 1

ALL APPLICANTS MUST COMPLETE AND RETURN PAGE 1 UNLESS CURRENTLY VOLUNTEERING AT HUP

Penn Medicine

Tuberculosis Screening Record for College Volunteers

Please print clearly

Applicant Name: *(Last, First, M.I.)*		**Today's Date:**	
		Date of Birth:	

All the information above must be completed in order to process this form.

If you have any questions, contact Volunteer Services at (215) 662-2576

Email to college.volunteer@uphs.upenn.edu or fax to (215) 614-0465

This form must be completed and signed by your healthcare provider

OR

Include with this form a negative screening for tuberculosis using one of the tests listed below. Attached screening must be on clinic letterhead, state the volunteer's name, indicate the test used, list the patient's date of birth, and be signed by a clinician.

Tuberculosis Screening

	☐ Negative PPD	☐ Negative Quantiferon Gold	☐ Negative T-Spot	☐ Chest X-Ray or Symptom Check
Tests & Dates: Please check all that apply & date	*Implant Date:_____*	*Date:_____*	*Date:_____*	*Date:_____*
	Reading Date:_____	**Must be completed within 90 days of start date*	**Must be completed within 90 days of start date*	**Must be completed within 365 days of start date*
	**Must be completed within 90 days of start date*			*Only needed if positive PPD, QG or T-Spot*
	Other Information:			

Healthcare Provider Name (please print):	
Healthcare Provider Signature:	
Healthcare Provider License #:	
Date:	

Influenza Vaccination

(required between October-April)

Date of Vaccination:	

PLEASE ATTACH DOCUMENT OF IMMUNIZATION AS PAGE 3

PAGE 2

ONLY NEW* VOLUNTEERS NEED TO COMPLETE AND RETURN PAGE 2

Penn Medicine

Immunization History Record for College Volunteer

Please print clearly

Applicant Name: (Last, First, M.I.)		**Today's Date:**	
		Date of Birth:	

All the information above must be completed in order to process this form.
If you have any questions, contact Volunteer Services at 215-662-2576
All persons working with patients or families, or routinely working in a building where patients are seen, must provide proof of immunity as indicated.
This form must be completed and signed by your healthcare provider.

Measles (Rubeola), Mumps, & Rubella

	☐ Positive Titers	☐ MMR Vaccine	☐ Measles Vaccine	☐ Mumps Vaccine	☐ Rubella Vaccine
Immunizations & Dates: Please check all that apply & date	Measles Date:_____	Date #1:_____	Date #1:_____	Date #1:_____	Date:_____
	Mumps Date:_____	Date #2:_____	Date #2:_____	Date #2:_____	n/a
	Rubella Date:_____	Other Information:			

Varicella (Chicken Pox)

	☐ ELISA Titer	☐ Varicella Vaccine	☐ Shingles Vaccine
Immunizations & Dates: Please check all that apply & date	Date:_____	Date #1:_____	Date:_____
	Results:_____	Date #2:_____	n/a
	Other Information:		

Healthcare Provider Name (please print):	
Healthcare Provider Signature:	
Healthcare Provider License #:	
Date:	

*New Volunteer is defined as a volunteer who has never volunteered in the HUP Volunteer Services Program or has not volunteered within the last two years.