



OhioHealth

HEALTH ASSESSMENT CONSENT FOR MINOR VOLUNTEERS

I, _____, hereby consent to give permission for OhioHealth, Associate
(Name of Parent/Guardian)
Health and Wellness, to conduct annual T.B. testing on _____.
(Name of Minor Volunteer)

I also authorize Associate Health and Wellness to conduct a health assessment for those wishing to volunteer in the Emergency Department or the Obstetric and Newborn areas. A health assessment involves reviewing immunization records and possibly doing bloodwork to determine immunization status. It may be necessary for the volunteer to obtain certain immunizations prior to working in these areas.

Facts concerning the minor’s medical history, including allergies, medications being taken, and any physical impairments or medical conditions to which a physician should be alerted are as follows:

Signature of Parent/Guardian

Date

Printed Name

Relationship

Contact Information:

Phone Number

Address