UCLA Health

VOLUNTEER SERVICES

MINOR STUDENT VOLUNTEER MEDICAL CLEARANCE

Individual's Full Name ____ Date of Birth ______/______/______

Address ____ UID: ____________________________

____

Home Phone (_______)__________________________________ Mobile Phone (______)___________

Employer/Dept ____ Job Title ________________________

To insure the safety of individuals, patients, clients and staff all those working at UCLA Health must be screened for potentially infectious diseases and conditions, as recommended by the Centers for Disease Control and Prevention.

Please return **completed** form to your department: ____

Individual must obtain medical clearance, as delineated on this form, by a physician **prior** to working on UCLA Health premises.

1. Individual must have **proof of immunity**, (e.g. blood titers), to the following conditions:
   - Measles (Rubeola)
   - Mumps
   - Rubella (German Measles)
   - Varicella
2. Individual must be either
   - Offered and given the Hepatitis B vaccine series, or
   - Demonstrate immunity to Hepatitis B, or
   - Sign a declination for Hepatitis B vaccination
3. Individual must be tested for Tuberculosis by the "2 Step Tuberculin Skin Testing" AND be free of active tuberculosis. Individual must be Tuberculin Skin Tested annually, thereafter, and be free of active tuberculosis at all times.
4. Individual must be offered the Tdap (Tetanus, Diphtheria, Pertussis) Vaccine.
5. Individual must be offered the Flu Vaccine during flu season. If an individual declines the flu vaccine, the individual must sign a declination.
6. Individual must be physically and medically cleared by a physician to perform the essential functions of the job, as outlined in the job description.

Comments (Work Restrictions/Work Accommodations): attach additional pages if needed*

*This information, including work restrictions, is used to determine potential accommodations. The information is not utilized to discriminate.

Physician's Statement:

I certify this individual, ____________________________, has met UCLA Health's medical clearance criteria delineated on this form, and does not represent a communicable disease safety risk; and I certify the individual can perform the essential functions of the job and does not represent a safety risk in a medical hospital environment, except as noted in the Comments Section.

Physician Full Name ____________________________________ Office Phone (______)_________________

Address ____________________________________ Medical License # _________________________

____________________________________ Specialty __________________________

Physician Signature ____ Date ______/______/________