UCLA Health

VOLUNTEER SERVICES

MINOR STUDENT VOLUNTEER MEDICAL CLEARANCE

Individual's Full Name _____ Date of Birth _____/_____/_____

Address _____ UID: _____

_____

Home Phone (_____)_____ Mobile Phone (_____)_____

Employer/Dept Volunteer Services Job Title Volunteer/Other

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: ____**Volunteer Services**_____

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 immunizations 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 show documentation of a QuantiFERON-TB Gold (also known as QFT-G) blood test completed no more than 3 months prior to start date. Individual must be tuberculin 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 _____/_____/_____