CORNELL HEALTH
110 Ho Plaza , Ithaca, New York 14853-3101
(607) 255-5155 Fax (607) 255-0269

VOLUNTEER/MENTORSHIP/EDUCATIONAL SESSION HEALTH ASSESSMENT

Name: _____ Date: _____

ID: _____ DOB: _____

The New York State Department of Health has regulations which require that employees and volunteers of health care facilities be free of health impairments which would present a risk to patients or which might interfere with the performance of professional duties. The regulations require an annual reassessment of the health status of participant.

IN THE PAST 12 MONTHS

Have you had an illness or injury that required medical treatment which would pose a risk to patients or other employees or would interfere with your ability to perform your duties? ◯ YES ◯ NO
If yes, list date _____ explain_____

Were you hospitalized or did you have a surgical procedure which would interfere with your ability to perform your duties or could pose a risk to patients or other employees? ◯ YES ◯ NO
If yes, list date _____ explain_____

Have you had any recurring rashes or skin conditions? ◯ YES ◯ NO
If yes, list date _____ explain_____

Have you had a chronic productive cough with unexplained weight loss, fever, night sweats or coughing up blood? ◯ YES ◯ NO
If yes, list date _____ explain_____

Have you had abdominal pain accompanied by fever, nausea, vomiting, diarrhea or jaundice? ◯ YES ◯ NO
If yes, list date _____ explain_____

Are you taking any medications that would interfere with your ability to perform your duties? ◯ YES ◯ NO
If yes, explain _____

Do you have any drug or alcohol dependency? ◯ YES ◯ NO
If yes, explain _____

Have you undergone treatment for any other medical or psychological condition that would interfere with the performance of your duties or pose a risk to patients or other staff? ◯ YES ◯ NO
If yes, list date _____ explain_____

To the best of my knowledge, the information included herein is true.

Student Name: _____ Student ID # _____

Student Signature: _____ Date: _____

Date reviewed by CH:_____ Reviewed by (signature):_____

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Tuberculosis screening requirements:

2 step PPD within 12 months:
PPD placement date:_____ Date read:_____ Result: _____

PPD placement date:_____ Date read:_____ Result: _____

OR

QUANTIFERON GOLD blood test:
Date:_____ Result: _____

If positive result tuberculosis screening:
X-ray completed on:_____ Findings:_____
Plan:

Immunization requirements:

MMR Dose 1: _____ Dose 2:_____ Additional Dose: _____
Varicella Dose 1: _____ Dose 2: _____
Date of most recent seasonal flu vaccine: _____

COVID-19 Vaccination:

Manufacturer Dose 1:_____ Date:_____
Manufacturer Dose 2:_____ Date:_____
Manufacturer Dose 3:_____ Date:_____
Manufacturer Dose 4:_____ Date:_____

Clinician Name: _____ Title:_____
Clinician Signature: _____ Date: _____