

NORTHSIDE HOSPITAL ATLANTA AUXILIARY

TEEN MEDICAL HISTORY/PARENTAL CONSENT FORM

Name _____ Sex _____
(Last, First, Middle Initial)

Home Address _____

Phone _____ Birthdate _____ School _____

In Case of Emergency, please notify:

Daytime Phone _____ Relationship _____

The Administration at Northside Hospital-Atlanta needs written consent for Volunteens to receive emergency treatment in the event of a serious illness or accident and you cannot be contacted.

PARENT/LEGAL GUARDIAN'S APPROVAL _____

RELATIONSHIP _____ DATE _____

HISTORY

1. List all drugs and medications the Volunteen is presently taking.

Drug	Dosage
_____	_____
_____	_____

2. List any allergies _____

3. Two TB skin tests are required prior to Volunteen beginning the program. Tests may be given and read at the Employee Health offices in Atlanta, Forsyth or Cherokee, Pre Surgery Assessment at our Alpharetta Medical campus or your County Board of Health. Each test must be read 48-72 hours after the test is administered. ***This permission includes TB Surveillance for both TB skin test and a chest x-ray if necessary.***

PARENT/LEGAL GUARDIAN'S APPROVAL _____

RELATIONSHIP _____ DATE _____

IMPORTANT.....

(MUST HAVE THIS TO PROCESS)

In addition, proof of having received **two (2) doses** of measles, mumps, rubella (MMR) vaccine since the student’s first birthday is required. These records can be obtained from the pediatrician or school immunization records. **Please attach a copy of the immunization record to this form.**

PLEASE READ CAREFULLY BEFORE SIGNING

I certify that all information provided in this questionnaire is true and correct to the best of my knowledge. I understand that any falsification or significant omission of any information requested herein will be considered sufficient cause for discharge without prior warning at any time during my child’s assignment with Northside Hospital-Atlanta.

I also understand that periodic examinations are required of all hospital personnel for my child’s protection and that of patients, visitors and other employees, and that failure to submit to any medical examination requested by the hospital will be considered cause for termination. I further authorize any hospital, clinic or physician(s) to release to Northside Hospital any information relative to medical history, physical and mental condition for purposes of (1) verifying the information provided on this form, (2) approving disability insurance benefits, or (3) determining my child’s ability to perform his/her assigned job duties. I further agree that this authorization will be valid throughout his/her assignment at Northside Hospital.

PARENT/LEGAL GUARDIAN SIGNATURE_____

VOLUNTEEN SIGNATURE_____

DATE_____

APPLICATION PACKET MUST BE COMPLETE AND EITHER MAILED OR HAND-DELIVERED. NO INCOMPLETE OR FAXED PACKETS WILL BE ACCEPTED AND THE APPLICANT MAY NOT REAPPLY IN 2012.