

Have you ever had or do you now have any of the conditions listed below? For all yes answers, list approximate date/year of treatment and explain treatment briefly.

	<u>No</u>	<u>Yes</u>	<u>Explanation of Answer</u>
Alcoholism	_____	_____	_____
Arthritis	_____	_____	_____
Asthma/Emphysema	_____	_____	_____
Back Trouble	_____	_____	_____
Cancer	_____	_____	_____
Chest Pains	_____	_____	_____
Diabetes	_____	_____	_____
Drug Abuse	_____	_____	_____
Epilepsy/Seizures	_____	_____	_____
Fainting/Dizziness	_____	_____	_____
Hernia	_____	_____	_____
Hearing Problem	_____	_____	_____
Heart Disease	_____	_____	_____
Hepatitis	_____	_____	_____
High Blood Pressure	_____	_____	_____
High Cholesterol	_____	_____	_____
Knee/Foot/Ankle/ Problem	_____	_____	_____
Liver Disease	_____	_____	_____
Nervous Breakdown/ Psychiatric Illness or treatment	_____	_____	_____
Obesity (> 20 pounds overweight)	_____	_____	_____
Stroke	_____	_____	_____
Surgery	_____	_____	_____
Ulcers	_____	_____	_____
Vision Problem	_____	_____	_____
Other	_____	_____	_____

I hereby declare that my answers to the above questions are complete and true. I agree that any false statements shall be sufficient cause for dismissal. I hereby grant permission to St. Luke's Episcopal Hospital to investigate any information included in this form, and to contact my personal physician (listed on page 1 of this form) with regard to the information given. I understand that any information given to St. Luke's Episcopal Hospital by myself or my physician will remain confidential.

Signature of Volunteer _____ Date _____

For Volunteer Less than 18 Years of age the signature of a parent or legal guardian is required:

Signature of Parent/Guardian _____ Date _____

Printed Name of Parent/Guardian _____ Day Time Phone Parent or Guardian _____

EMPLOYEE HEALTH:

Date Outside Health Review Received: _____

Date Volunteer Cleared by Employee Health: _____

Employee Health Nurse

Date