THE JUNIOR LEAGUE OF HOUSTON, INC. MEMORANDUM

TO: **2020 – 2021 Provisional Members**

FROM: **Alicia Lee, Texas Children's Hospital Chairman**

SUBJECT: **Texas Children's Hospital Health History Questionnaire**

DATE: **Wednesday, March 18, 2020**

All volunteers (except those in Sewing for TCH) will need to complete the Health History Questionnaire (attached).

Segment I Volunteers
The Volunteer Health History Questionnaire must be completed and brought in hard-copy, along with your immunization record, on **Monday, May 11, 2020,** when Segment I volunteers take the TB skin test and badge photo.

Segments II, III and IV Volunteers
The Volunteer Health History Questionnaire must be completed by **Tuesday, August 11, 2020.**

Prior to Tuesday, August 11, provisional members may return the Volunteer Health History Questionnaire to Alicia Lee, Texas Children's Hospital Chairman, via

- Email at leealiciad@gmail.com;
- The Texas Children's Hospital Chairman mailbox on the second floor of the League; or
- Mail to The Junior League of Houston, Inc. Attn: Texas Children's Hospital Chairman, 1811 Briar Oaks Lane, Houston, TX 77027.

On Tuesday, August 11, 2020, provisional members may bring a hard-copy of the Volunteer Health History Questionnaire, along with the immunization records, with you for when you take your TB skin test and badge photo.

Questions
All questions about the Volunteer Health History Questionnaire should be directed to Alicia Lee, Texas Children's Hospital Chairman, at 713.828.3798 or leealiciad@gmail.com.

Texas Children's Hospital
Integrated Delivery System

VOLUNTEER HEALTH HISTORY QUESTIONNAIRE

Volunteer Coordinator_____
Phone Number_____

NAME _____ DATE _____
MALE _____ FEMALE _____
CONTACT PHONE # _____ AGE _____ DOB _____
E-MAIL ADDRESS _____

PERSONAL PHYSICIAN'S NAME _____
PHYSICIAN'S PHONE _____
IN EMERGENCY, NOTIFY _____ PHONE# _____

CHILDHOOD DISEASE HISTORY (Please include documentation) VACCINE HISTORY (Include all dates)

Chicken Pox [ ] Yes [ ] No _____Tdap vaccine within 10 years [ ] Yes [ ] No _____
Rubella (German Measles) [ ] Yes [ ] No _____Measles, Mumps, Rubella (MMR) [ ] Yes [ ] No
Rubeola (Red Measles) [ ] Yes [ ] No _____1st _____2nd _____
Mumps [ ] Yes [ ] No _____Varicella Vaccine [ ] Yes [ ] No 1st _____2nd _____

*Submit a copy of your required immunization record.
*Please Note: If no immunization record is available, please submit blood test confirmation of immunity for Rubella, Rubeola (Measles), Mumps, and Varicella (chickenpox) will be accepted.

PPD (Mantoux Tuberculin Skin Test)

Hospital policy requires a Mantoux Tuberculin Skin Test in the current calendar year.
The test must be read between 48 and 72 hours. The following information must be recorded:

Date Placed _____Date Read _____

Negative _____ Positive/mm of induration _____

Signature & Title of Doctor or Registered Nurse reading the PPD Skin Test:

Name _____ Title_____
(Signature only, no stamp)

ARE YOU CURRENTLY PREGNANT? YES _____ NO _____

PLEASE LIST ALL PRESCRIPTION MEDICATIONS THAT YOU ARE CURRENTLY TAKING:
_____

Do you have any health concerns which might limit your ability to perform certain volunteer responsibilities?

Yes_____ No_____
If yes, please explain:
_____
_____
_____

(over)

Have you ever had or do you now have any of the listed conditions? Explain when and where a treatment was received for all "YES" answers in the space provided. Please note that incomplete answers may cause a delay in your ability to begin volunteering.

	NO	YES	DATE	IF YES, EXPLAIN
Alcoholism				
Arthritis				
Asthma/Emphysema				
Back Trouble				
Breathing Difficulty				
Cancer				
Chest Pains				
Diabetes				
Drug Abuse				
Epilepsy/Seizure				
Fainting/Dizziness				
Hearing Problem				
Heart Problem				
Hepatitis				
High Blood Pressure				
Knee, Foot or Ankle Problem				
Liver Disease				
Psychiatric Illness or Treatment				
Stroke				
Surgery				
Vision Problem				
Other				

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

Signature of Volunteer _____ Date _____