Employee Health/Consent-to-Test/Right-to-Know

Informed Consent

I, ________________________________, understand I will provide a blood sample.

(Print Name)

The blood will be used to evaluate immunization status. **DO NOT FAST for this testing.** Please eat regular meals and drink plenty of fluids.

*Bring immunization records to your appointment.*

Blood Draw:

____ Measles/Mumps/Rubella (MMR)

____ Tuberculous (TB)

I have read, or had explained, the information regarding Measles, Mumps, Rubella, Tetanus and Varicella diseases and vaccines. I have had a chance to ask questions and have them answered to my satisfaction. I understand the benefits and risks of the vaccines and request the vaccine checked above be administered.

*Signature* ________________________________

Release of Information:

The Employee Health/Disability Management Department is hereby authorized to release any of the above information and related test results to Volunteer Services.

*Signatures:*

Junior Volunteer ________________________________ Date________________

Parent/Guardian ________________________________ Date________________