OhioHealth

Associate Health

Parental Consent for Minor Volunteers

I, _____ hereinafter ("Parent or Guardian") hereby consent to give permission to OhioHealth Corporation's, Associate Health to provide the following services for my child or legal guardian:

- **TB Testing** (TB Testing may be conducted by skin testing or blood draw. Initial baseline testing is required. Periodic testing may be required depending on TB Risk Level of the institution.)
- **Annual Influenza Vaccine** (Required unless exempted for medical or religious reasons. Must file an exemption form annually if applicable.)
- **Health Assessment and Other required Immunizations: Documentation:**
    a. MMR (Required)
        i. Written Documentation of 2 MMR vaccines given 28 days apart or
        ii. Lab results indicating immunity to rubeola, mumps, and rubella (all three are required)
    b. Varicella – Chickenpox (required)
        i. Written Documentation of Varicella vaccines given 28 days apart or
        ii. Lab results indicating immunity to varicella
    c. Hepatitis B (Strongly recommended)
        i. Written evidence of up to 6 vaccines with lab results indicating immunity

We ask that documentation of your vaccines from your physician's office be provided with your Volunteer Application. Once this documentation has been received, a nurse will review it. The nurse will contact you and let you know whether additional lab testing or immunizations are needed. If you are not able to provide the above documentation, please contact Associate Health at **614-566-4884.**

Parent or Guardian may be asked to sign separate consents for individual vaccines and/or accompany the volunteer to an immunization appointment. Health information will be kept private in compliance with the Health Information Portability and Accountability Act (HIPAA) and OhioHealth policy.

Please list any allergies or medical conditions that Associate Health should be aware of while your child is volunteering:

_____

_____

Parent/Guardian Signature: _____ Date: _____

Relationship: _____ Home Phone Number: _____ Cell Number: _____

Minor Volunteer's Name: _____

Birth Date: _____ Volunteer Hospital Location: _____

Address: _____

Home Phone Number : _____ Cell Number : _____