New York State Dental Association

Health Assessment for Volunteers

NYS Department of Health requires all providers working at Art. 28 and FQHC facilities to have required vaccines.

Volunteer Name: ___ _____ Date of Birth: ____/____/_____

1. **Tuberculin Skin Test (PPD)**

   ☐ Skin test (PPD) performed: _____/_____/_____

   Results:

   ☐ Negative (must be performed annually)

   ☐ Positive/Active TB ruled out

   ☐ Excluded from requirement/no clinical signs/symptoms suggestive of active TB

   Check reason:

   ☐ Significant Prior Reaction

   ☐ Adequate treatment of known prior disease

   ☐ Completion of adequate preventive drug therapy

   ☐ Pregnancy

2. **Influenza Vaccine**

   ☐ Administered on: _____/_____/_____

   ☐ Declination of Influenza Vaccine

3. **Documentation of vaccination history**

   ☐ Measles ☐ Rubella

   ☐ MMR

I have determined that the above named individual is free from any health impairment which is of potential risk to patients or which might interfere with the performance of his or her duties, including the habituation or addiction to depressants, stimulants, narcotics, alcohol or substances which may alter the individual's behavior.

Practitioner Signature: _____ Date of Exam: _____/_____/____

Typed or Printed name: _____