

# The Hebrew Home at Riverdale

5901 Palisade Avenue  
Riverdale, NY 10471  
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Hebrewhome.org

## VOLUNTEER HEALTH EXAMINATION RECORD

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician: \_\_\_\_\_

Applicant: \_\_\_\_\_

Physician's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

The above applicant has applied for volunteer service at the Hebrew Home at Riverdale. The work at times may include patient contact and handling of food.

**IN COMPLIANCE WITH THE NEW YORK STATE HEALTH CODE, VOLUNTEERS MUST HAVE A RECORDED MEDICAL HISTORY AND PHYSICAL EXAMINATION PRIOR TO WORKING. WE WOULD APPRECIATE YOUR FILLING OUT THE FOLLOWING QUESTIONNAIRE:**

1. How long have you known the applicant? \_\_\_\_\_
2. Does the applicant have any health impairments which might:
  - a) Present a potential risk to themselves, residents, or Hebrew Home personnel?  
\_\_\_\_\_  
\_\_\_\_\_
  - b) Interfere with the performance of his/her duties?  
\_\_\_\_\_  
\_\_\_\_\_
3. Is the applicant habituated or addicted to non-prescription drugs, alcohol or any other substance that may alter the individual's behavior? \_\_\_\_\_  
\_\_\_\_\_
4. Has the applicant had a complete medical and physical examination? Yes  No   
Please record the date of last physical examination: \_\_\_\_\_
5. Is there any physical or medical condition that the home should be aware of before assigning a position? Please explain: \_\_\_\_\_  
\_\_\_\_\_
6. May the applicant work directly with residents? \_\_\_\_\_
7. May the applicant transport residents in wheelchairs? \_\_\_\_\_

(over)

**THE NEW YORK STATE HEALTH CODE REQUIRES 2 TUBERCULIN TESTING ON NEW APPLICANTS.**

If the applicant is tuberculin POSITIVE, the result of a chest x-ray done within the past year is required.

If the applicant is tuberculin NEGATIVE, the tuberculin test MUST BE REPEATED EVERY YEAR.

Please record the date and result of tuberculin testing:

Date Planted	Date Read	Result

If tuberculin POSITIVE, date of last chest x-ray: \_\_\_\_\_

Chest X-ray Result (if applicable): \_\_\_\_\_

**PERSONNEL:**

**If born before 1957 you will only need:**

VARICELLA (CHICKEN POX)      Date of Immunization \_\_\_\_\_ or Date of Test: \_\_\_\_\_ Titer: \_\_\_\_\_

**If you were born after 1957 you will need:**

RUBEOLA (MEASLES)              Date of Immunization \_\_\_\_\_ or Date of Test: \_\_\_\_\_ Titer: \_\_\_\_\_

RUBELLA (GERMAN MEASLES)      Date of Immunization \_\_\_\_\_ or Date of Test: \_\_\_\_\_ Titer: \_\_\_\_\_

VARICELLA (CHICKEN POX)      Date of Immunization \_\_\_\_\_ or Date of Test: \_\_\_\_\_ Titer: \_\_\_\_\_

MMR VACCINE- 1<sup>ST</sup> DOSE              Date Given: \_\_\_\_\_

MMR VACCINE- 2<sup>ND</sup> DOSE              Date Given: \_\_\_\_\_

We would appreciate your returning this form as soon as possible. All responses will be kept confidential. The Hebrew Home is not financially responsible for medical tests.

\_\_\_\_\_  
Date:

\_\_\_\_\_  
Signature of Examining Physician