Authorization for Participation in Background Check, Screening, Testing, and/or Immunization and Disclosure of Protected Health Information for Prospective Volunteers under Age 18

Name of Prospective Student Volunteer (please print clearly) ______________________________ 
Name of Parent and/or Legal Guardian (please print clearly) ______________________________ 

I certify that I am the parent and/or legal guardian of the above named underage prospective volunteer of Perham Health.

I understand that the volunteer position requires a background check through DHS. I understand that the position may require immunizations, tuberculosis testing, lab tests, titer testing, and influenza shots. I authorize that my child or dependent may undergo any of the above listed as necessary.

I authorize full release of all medical information relating to pre-volunteer testing to representatives of Perham Health’s Volunteer and Employee Health Departments.

This information may include immunizations, tuberculosis testing, lab tests, titer results, and influenza shots.

I also authorize the sharing of information, as required, to public health records.

I may revoke this authorization at any time by sending written notice to the Volunteer Coordinator. This authorization expires one year following the termination of my volunteer assignment.

Signed (Parent or Legal Guardian) ___________________________________________________ 

Signed (Prospective Student Volunteer) ________________________________________________

Date ________________________________

Please send completed form to maggie.fresonke@perhamhealth.org