THE KELBERMAN CENTER
AUTISM SERVICES ACROSS THE LIFESPAN
AN AFFILIATE OF UPSTATE CEREBRAL PALSY

Volunteer Health Assessment

Volunteer Name____

Mailing Address____

Telephone: Home ___________________________ Work _______________________

Birth Date ________________________________Sex: Male ____ Female__________
Emergency Contact ____
Relationship ____________________ Telephone: _____________Work __________
Who is your regular health provider?_______________________________________

Name____

Telephone ____

Please list any allergies____

Please list any physician indicated restrictions__________________________________
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Will you need any accommodations (due to physical, emotional, or developmental disability, heart disease, back injury, etc..) in order to provide volunteer services?______________
If yes, what kind of accommodations do you need?______________________________
____

I am not habituated or addicted to depressants, stimulants, narcotics, alcohol or other substances that may alter my behavior.____

The statements herein are true to the best of my knowledge.

Signature of Volunteer ____________________________ Date___________________

Please note: Assuring the safety and well-being of our consumers, staff, and volunteers is essential to the provision of services. Therefore, if after review of this health assessment the Volunteer Development office, upon advice from the Medical Director, determines that the safety and well-being of consumers, staff or volunteers are in jeopardy, the Volunteer Development office may request the prospective volunteer to submit a health report from their health provider before being placed in a volunteer position. If this is necessary, the costs associated with the health report will be borne by the volunteer