Illinois and Iowa Volunteer Requirements - Students

Thank you for your interest in volunteering at one our Skip-a-Long locations! To ensure high quality care and maintain licensing standards, volunteers who work in a classroom MORE THAN ONCE PER MONTH are required to obtain the below documentation. We can provide you with all necessary forms that need to be completed by email, fax, or you may pick them up at the Moline Business Administration office. **You are welcome to utilize your own physician for Physical and TB testing, or you can visit one of the locations below**. When you have proof of the following please send or drop it off to Human Resources, 4210 44th Ave., Moline, IL 61265. If you have any questions, please contact the HR Director at (309) 764-3724 or humanresources@salfcs.org.

Student Volunteers at all Skip-a-Long centers will need the following:

- **Physical**- We will provide you with the necessary documents, depending on center
- **TB Test**

TB Tests and Physicals can be obtained at:

RI County Health Department –TB Only 2112 25th Avenue Rock Island, IL 61201 Hours: 8:00 AM to 4:30PM Monday mornings or Tuesday afternoons only Phone: 309-793-1955 **Appointment Required** **Cost: $25.00**	**Concentra and IWRC –Physical and TB Test** 3540 E. 46th Street Davenport, IA 52807 Phone: 563-359-1170 **Appointment Recommended** **Physical: $38.00** **TB Vaccine: $42.50** **Vaccine (Read 48 hours later is free of charge)**

Scott County Health Department –TB Only 600 W. 4th St. Davenport, IA 52804 Hours: 8:00 AM to 4:30PM Phone: 563-326-8618 **Appointment Required** **Cost:**	**Concentra and IWRC –Physical and TB Test** 3540 E. 46th Street Davenport, IA 52807 Phone: 563-359-1170 **Appointment Recommended** **Physical: $38.00** **TB Vaccine: $42.50** **Vaccine (Read 48 hours later is free of charge)**

Volunteer Application

SAL Family and Community Services

Partners Together… Improving Lives

Title (Mr., Mrs., etc.) First Name Last Name

Home Address Line 1

Home Address Line 2

City State ZIP Code

Home Phone Number Work Phone Number Cell Phone Number

Email Address

Are you 16 years or older? (you must be at least 16 to serve as a volunteer) ◯ yes ◯ No

Are you a student or completing volunteer hours as community service? ◯ Student ◯ Need Service Hours

At which location(s) are you interested in volunteering?

Davenport Campus ☐ Milan Campus ☐ Moline Campus ☐

Rock Island Campus ☐ I am interested in other volunteering opportunities (Open Door, serving on a committee, special events, etc.) ☐

Please indicate the day(s) and time(s) you are available to volunteer. Time frames below are suggested but can be flexible to fit your schedule or needs:

Mondays:		**Tuesdays:**		**Wednesdays:**	
9:00am—11:00am	☐	9:00am—11:00am	☐	9:00am—11:00am	☐
1:00pm—3:00pm	☐	1:00pm—3:00pm	☐	1:00pm—3:00pm	☐
3:00pm—5:00pm	☐	3:00pm—5:00pm	☐	3:00pm—5:00pm	☐

Thursdays:		**Fridays:**		**Weekend days:**	
9:00am—11:00am	☐	9:00am—11:00am	☐	Saturday	☐
1:00pm—3:00pm	☐	1:00pm—3:00pm	☐	Sunday	☐
3:00pm—5:00pm	☐	3:00pm—5:00pm	☐		

How many hours per month would you like to volunteer?

1—4 hrs. per month ☐ 5—9 hrs. per month ☐ 10—15 hrs. per month ☐

If you would like to volunteer more than 15 hours per month please state how many hours you would like: _____

With which age groups are you interested in volunteering?

Infants (0-12 mos. old) ☐ Toddlers (13-24 mos. old) ☐ Two Year Olds ☐

Preschoolers (3-5 yrs. old) ☐ School-age (6-12 yrs. old) ☐

What date are you available to start? _____

In case of emergency, please contact (include name, phone number, address):

Agreement and Signature:

By submitting this application, I affirm that the facts set forth in it are true and complete. I understand that if I am accepted as a volunteer, any false statements, omissions, or other misrepresentations made by me on this application may result in my immediate dismissal.

_____ _____

First and Last Name Today's Date

It is the policy of this organization to provide equal opportunities without regard to race, color, religion, national origin, gender, sexual preference, age, or disability. Thank you for your interest in volunteering with us.

SAL Family and Community Services

Partners Together... Improving Lives

SALFCS Volunteer Form - TB Testing

Patient responsible for payment - ***Take to physician to complete***

TB Test Results

Name: _____Birthdate: _____

Have you ever had a Tuberculosis (TB) skin test? ☐ Yes or ☐ No
What were the results of that test? ☐ Negative or ☐ Positive
Were you given Oral Polio or MMR in the last two months? ☐ Yes or ☐ No

Are you pregnant? ☐ Yes or ☐ No
Have you had any major surgeries? ☐ Yes or ☐ No If so What type and when? _____
_____
_____

Are you currently taking any medications? ☐ Yes or ☐ No What kind? _____
_____

Do you have allergies to any medications? ☐ Yes or ☐ No If yes what: _____
_____

Do you currently have any illnesses? ☐ Yes ☐ No If yes what: _____
_____

Signature: _____Date: _____

Date given: _____Given by: _____ Mantoux PPD-T Lot: _____
Date read: _____ Read by: _____ Reading: ☐ Positive or ☐ Negative

Date given: _____Given by: _____ Mantoux PPD-T Lot: _____
Date read: _____ Read by: _____ Reading: ☐ Positive or ☐ Negative

Date given: _____Given by: _____ Mantoux PPD-T Lot: _____
Date read: _____ Read by: _____ Reading: ☐ Positive or ☐ Negative

Date given: _____Given by: _____ Mantoux PPD-T Lot: _____
Date read: _____ Read by: _____ Reading: ☐ Positive or ☐ Negative

CFS 602
Rev. 03/2016

STATE OF ILLINOIS
Department of Children and Family Services

MEDICAL REPORT ON AN ADULT IN A CHILD CARE FACILITY

(Includes employees and volunteers in DCFS licensed child care facilities, operators of day care/group day care homes and other adult members of their households)

_____ _____
(Name of Person Examined) (Birth Date)

Position (check one)

- ☐ Day Care/Group Day Care Home Caregiver
- ☐ Child Care Staff
- ☐ Other Staff in a Child Care Facility
- ☐ Member of Household
- ☐ Food Handler (See Section B)
- ☐ Child Care Facility Driver (See Section B)
- ☐ Volunteer in a Child Care Facility

Name of Licensee/applicant for License or Licensed Facility where individual is employed/volunteers _____

Address _____
Street City Zip Code County

I. TESTS

	Date	Results
Tuberculin test (by the Mantoux method or chest X-ray in a positive reactor)*		
Other (specify):		

II. IMMUNIZATIONS

☐ Yes ☐ No I have discussed the importance of immunizations for adult child care providers with this individual and recommend the following immunizations: _____

If this individual is employed in a child care facility that cares for children age 6 and under, please check two of the following:

This individual has received: ☐ 1 dose of the Tdap vaccine ☐ 2 doses of the MMR vaccine **or** is immune to MMR.

This individual is not medically indicated for: ☐ 1 dose of the Tdap vaccine ☐ 2 doses of the MMR vaccinations.

III. FINDINGS AND RECOMMENDATIONS

A. Findings

Summary of medical or emotional problems or conditions, if any, which may affect the individual's ability to work, volunteer or reside in a facility caring for children.

_____

_____

_____

B. Any conditions which contraindicate a person serving as a Food Handler or Child Care Facility Driver?
☐ Yes ☐ No If yes, please specify _____

C. Recommendations

The above individual was found free from symptoms of communicable disease and is otherwise medically and emotionally fit to work, volunteer or reside in a facility caring for children. ☐ Yes ☐ No
Explain "No": _____

In my opinion, the individual could meet the strength and mobility challenges required for caring for a child in one or more of the age groups checked below:

☐ 0-2 years of age ☐ 2-6 years of age ☐ 7-12 years of age ☐ 12-18 years of age

_____ _____
Date of Examination Physician's Name (Print) and State License Number

_____
Physician's Signature

_____
Street Address City State Zip Code

_____
Telephone Number

* Required in initial examination only. Physician to determine need for test in subsequent examinations.

REEXAMINATIONS

Date of Examination | Physician's Name (Print) and State License Number

Date of Examination | Physician's Name (Print) and State License Number

Date of Examination | Physician's Name (Print) and State License Number

Date of Examination | Physician's Name (Print) and State License Number

Date of Examination | Physician's Name (Print) and State License Number

Date of Examination | Physician's Name (Print) and State License Number

Iowa Department of Human Services

Child Care Provider Physical Examination Report

Child Care Center Personnel • Child Development Home Providers

Name	Date of Examination

Patient may:

- ✓ have very frequent contact with children (infant through school-age) in care.
- ✓ be responsible for children's physical care and social development during day and nighttime hours.
- ✓ need to lift children, bend, and stand for long periods of time.

Child Care Provider Health Concerns (Please check all that apply.)

- ☐ Allergies
- ☐ Breathing problems (asthma, emphysema)
- ☐ Diabetes or problems like thyroid, other
- ☐ Heart, blood pressure problems
- ☐ Vision
- ☐ Illegal or prescription drug abuse
- ☐ Neurologic problems (epilepsy, Parkinsonism, other)
- ☐ Smoking or alcohol use
- ☐ Susceptibility to infection, illness
- ☐ Stomach or bowel problems
- ☐ Skin problems (eczema, rashes, conditions incompatible with frequent hand washing, other)
- ☐ Emotional or nervous problems (depression, difficulty handling stress)
- ☐ Musculoskeletal problems (low back pain, susceptibility to back injury, neck problems, arthritis)
- ☐ Hearing or difficulty hearing in a noisy environment
- ☐ Other (explain):_____

_____

_____

Immunization Status

All child care employees and providers shall consult with their physician regarding the receipt of age appropriate immunizations in accordance with the current Advisory Committee on Immunization Practices (ACIP) recommended immunization schedule. Individuals involved in the provision of child care often come in contact with very young children, whom may or may not be fully immunized against vaccine-preventable diseases. It is essential every child care employee and provider discuss with their physician the benefits and risks associated with receiving or not receiving all ACIP age appropriate immunizations before becoming involved in a child care setting.

(PHYSICIAN MUST CHECK ONE AND DATE)

- ☐ Patient's immunization history was reviewed and patient is current with all ACIP recommended immunizations.
- ☐ Patient received consultation regarding the receipt of age appropriate immunizations in accordance with the current ACIP recommended immunization schedule and declined the following recommended vaccinations:

_____

_____

Date:_____

Tuberculosis Screening

All child care employees and providers shall receive a baseline screening for Tuberculosis. Baseline screening shall consist of two components:

1. Assessing for current symptoms of active TB disease.
2. Screening for risk factors associated with TB.

Those individuals identified as belonging to a defined high-risk group or who have signs or symptoms consistent with TB disease shall be evaluated for TB infection and TB disease.

(PHYSICIAN MUST COMPLETE AND CHECK AND DATE BOTH BOXES)

☐ TB signs and symptoms screen completed Date:_____

☐ TB risk factor screen completed Date:_____

** ***Tuberculosis medical consultation and TB medications can be accessed by calling the Iowa Department of Public Health, Tuberculosis Control Program at 515-281-8636 or 515-281-7504.***

Other Communicable Diseases and Overall Health Status

Does the individual have a known communicable disease or other health conditions that poses a threat to the health, safety, or well-being of children? ☐ Yes ☐ No **(If yes, describe in detail below.)**

Does the child care provider have a condition that limits the provider's ability to safely supervise or evacuate multiple dependent children in case of emergency? ☐ Yes ☐ No **(If yes, describe in detail below.)**

_____

_____

_____

Conclusion

☐ Individual may be involved with child care

☐ Individual may be involved with child care, with the following accommodations and restrictions (please describe below)

☐ Individual may not be involved with child care

Necessary Accommodations or Restrictions to Meet the Demands of Providing Child Care

(Please detail.)

_____

_____

_____

Health Care Provider Signature	Date
Mailing Address	Telephone
Provider Type: ☐ MD ☐ DO ☐ PA ☐ ARNP	Iowa License Number