UNIVERSITY of MARYLAND
CHARLES REGIONAL MEDICAL CENTER

VOLUNTEEN PERMISSION SLIP

PARENTS: ***BOTH PERMISSION BLOCKS MUST BE SIGNED***

1. **I/We_____, the parents/guardians of _____ understand the requirements of the Volunteen Program at the University of Maryland Charles Regional Medical Center. I/We give my/our permission for my/our son/daughter to serve in this program. I/We agree that areas of assignment for Volunteen hours will be determined based on the needs of the Medical Center.**

Signature of Parent/Guardian:_____

Relationship to Volunteen:_____

Address - Street/P.O. Box:_____

City/State/Zip:_____

Tel. No(s). Home:_____

Work:_____

2. MEDICAL SCREENING REQUIREMENTS PERMISSION SLIP

I give permission for _____ to receive a skin test for Tuberculosis (PPD) at the University of Maryland Charles Regional Medical Center as required for all volunteers. You may also obtain a QuantiFERON blood test at your own expense, at the lab/physician office of your choice, in lieu of a 2-step PPD skin test.

In the event my son/daughter's Tuberculosis (PPD) test is positive, I give permission for him/her to receive a chest x-ray (free of charge) to test for active disease through the Employee Health Service at the University of Maryland Charles Regional Medical Center.

Signature of Parent/Guardian_____

Relationship to Applicant:_____

Address - Street/P.O. Box:_____

City/State/Zip:_____

Telephone Numbers:

Home:_____

Work:_____

Applicant's Social Security Number:_____

Applicant's Date of Birth:_____