Volunteers
1516 Atwood Avenue
Johnston, RI 02919
Phone: (401) 785-2666
Fax: (401) 785-2272

Under 18 Employment or Volunteer TB Permission Slip

To the parent/guardian of_____,

Your child has applied for volunteer work at **The Autism Project Social Skills Groups** or our **Summer Camp**. We are now an affiliate of Lifespan and require a Health Visit prior to volunteering. In order to provide a safe experience and to satisfy health regulations, we request that you provide the following before your child begins his/her volunteer work:

Childhood Immunization Record - See attached

Tuberculosis (TB) skin testing is done prior to the start of volunteer work on all volunteers who have a history of negative TB testing. Two TB tests are required; however, a volunteer may start after the first TB test and screening. TB testing is repeated at least annually by the hospital. There is no risk of transmitting tuberculosis to the person receiving the test. Rarely, a minor skin irritation may result from the test. If you cannot obtain a TB test(s) from your health care provider, then testing will be provided by Rhode Island Hospital at no cost. Volunteers with histories of positive TB tests require documentation of that positive test as well as a copy of the chest x-ray performed at the time of the positive TB test.

If your child needs TB testing through Rhode Island Hospital, then please read and sign the permission for TB testing below and return this form along with the completed Immunization Record to the Volunteer Office as soon as possible. Work will not be permitted until all the health requirements are met.

Please note that in the event of an emergency where the parent cannot be reached, the volunteer will be taken to the Rhode Island Hospital Emergency Department.

For questions, please call Jennie Moran, Office Manager at The Autism Project at 785-2666 x76787

I understand the above information and give permission for my son/daughter, _____to be provided with tuberculosis (TB) skin testing as is normally given to other Rhode Island Hospital and affiliate workers on a routine basis.

_____ _____

Signature of Parent or Guardian **Date**