PEN ARGYL AREA SCHOOL DISTRICT

VOLUNTEER INFORMATION FORM

Name: _____

Address: _____

Primary Phone #: _____ (Home/Cell/Work)

Additional Phone #s: _____ (Home/Cell/Work)

_____ (Home/Cell/Work)

Email Address: _____ (Home/Work)

Student Information:

Name	**School**
_____	_____
_____	_____
_____	_____
_____	_____

Tuberculin (TB) Test Statement

I intend to volunteer more than 10 hours a week (please check one):

- No
- Yes
  If "yes", please provide a current TB test. This can be obtained from your physician. The Pennsylvania Department of Health requires TB testing for all volunteers who will have direct contact with students for more than 10 hours per week.

  If you have any questions regarding TB testing, please contact your school's nurse.

Signature: _____ Date: _____