



**SENIORS IN SERVICE  
OF TAMPA BAY, INC.**

1306 W. Sligh Ave  
Tampa, FL 33604  
Ph. (813) 932-5228  
Fax. (813) 932-9604  
www.seniorsinservice.org

### ANNUAL PHYSICAL EXAMINATION

**Name of Volunteer:** \_\_\_\_\_

**Dear Physician:**

Please take time to consider the following information when signing this form. Our Senior Companions are very special to us and we would like to know that they will be able to safely perform the duties assigned to them.

Senior Companions serve at the VA Hospital, congregate meal programs and elderly clients in their homes for 15-30 hours per week.

**Senior Companion volunteers should be able to:**

- Travel from home to volunteer site
- Move from one place to another
- Sit for long periods of time
- Assist elderly with special needs
- Assist with meals
- Provide emotional support/empathy
- Assist with light housekeeping
- Go grocery shopping and run errands

**Please check one:**

- The volunteer named above has been evaluated /examined and was found to be free of communicable disease, and physically and mentally capable to serve 15-30 hours a week year-round as a Senior Companion.

A copy of his/her medical history, general examination findings and laboratory test results will be kept on file in the physician's office and available for reference, if needed, by the Senior Companion Program.

- At this time the Senior Companion is not able to perform the duties listed above.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Physician's Name (Printed) \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone Number \_\_\_\_\_ Fax Number \_\_\_\_\_

**This form may be faxed to (813) 932-9604 or mailed to 1306 W. Sligh Ave., Tampa, FL 33604  
(Por favor lleve esta forma a su Doctor para Examen Médico)**

# Emergency Contact / Health Information Contacto de Emergencia/Información de Salud

**Volunteer Name (Print)** \_\_\_\_\_ **Phone** \_\_\_\_\_  
(Nombre del Voluntario) (Teléfono)

<b>Emergency contact #1: (Contacto de Emergencia 1)</b>	<b>Emergency contact #2: (Contacto de Emergencia 2)</b>
<b>Name</b> _____ (Nombre)	<b>Name</b> _____
<b>Relationship</b> _____ (Relación con usted)	<b>Relationship</b> _____
<b>Phone # (home)</b> _____ (Tel. de casa)	<b>Phone # (home)</b> _____
<b>Phone # (work)</b> _____ (Tel. del trabajo)	<b>Phone # (work)</b> _____
<b>Phone # (cell)</b> _____	<b>Phone # (cell)</b> _____

**Type of health insurance:**  Original Medicare  Medicaid  Supplemental Policy  None  
(Tipo de seguro de salud)  Medicare/HMO  Other \_\_\_\_\_

**Preferred Hospital :** \_\_\_\_\_

**(Hospital de preferencia)**

**Primary Care Physician:** \_\_\_\_\_ **Phone:** \_\_\_\_\_  
(Nombre de Doctor primario) (Teléfono)

**Please list any significant health problems:**

(Lista de problemas de salud significativos)

- |          |          |
|----------|----------|
| 1) _____ | 3) _____ |
| _____    | _____    |
| 2) _____ | 4) _____ |
| _____    | _____    |

**Please list current medications:**

(Lista de medicamentos que este tomando)

- |          |          |
|----------|----------|
| 1) _____ | 3) _____ |
| _____    | _____    |
| 2) _____ | 4) _____ |
| _____    | _____    |

**Are you taking any medications/drugs that could impair your driving a vehicle?**  Yes  No

(Está tomando algún tipo de medicamento que pueda impedir que maneje un auto?)

**If yes, please explain:** \_\_\_\_\_

(Si contestó que sí, explique)

**Please list any allergies (dust, dogs, foods, medications, etc.). Check box if no known allergies.**

(Lista de alergias (polvo, perros, comidas, medicamentos, etc.) Marque no si no conoce tener alguna alergia.)

- |          |  |
|----------|--|
| 1) _____ | 3) _____                                     |
| _____    | _____  |
| 2) _____ | <input type="checkbox"/> No known allergies. |
| _____    | (No alergias conocidas)                      |

**Volunteer Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
(Firma de Voluntario) (Fecha)