SCHOOL YEAR: _____

SAN DIEGO UNIFIED SCHOOL DISTRICT
SCHOOL VOLUNTEER APPLICATION

DATE _____ DISTRICT SPONSOR _____ SCHOOL _____

FULL NAME _____
(FIRST) (MIDDLE) (LAST)

ADDRESS _____ DATE OF BIRTH _____
(STREET) (CITY) (ZIP) MO/DAY/YR

Gov Issued ID Type _____

HOME PHONE _____ E-MAIL _____ ID# _____

NOTIFY IN CASE OF EMERGENCY _____
(NAME) (PHONE)

CURRENT EMPLOYMENT _____
(EMPLOYER'S NAME) (ADDRESS) (PHONE)

VOLUNTEER EXPERIENCE _____

PERSONAL REFERENCE _____
(NAME) (ADDRESS) (PHONE)

Please check whether you are a new or returning SDUSD volunteer, ___New ___Returning

Are you also a volunteer at another SDUSD school? ___YES ___NO

If yes, please indicate the school(s): _____

Do you have any criminal charges pending against yon? ___YES ___NO

Have you ever been convicted* of a felony or misdemeanor? ___YES ___NO

Have you ever been convicted* of a sex, drug or weapon related offense? ___YES ___NO

Are you required to register as a sex offender under Penal Code 290,95? ___YES ___NO

*Conviction includes a finding of guilty by a court in a trial with or without a jury or a plea or verdict of guilty.

If "YES," please explain: _____

Parent Volunteers: Please check whether you plan to drive for a field trip during the school year, ___YES ___NO

Please list the name(s) of your child(ren): _____

For security reasons, a background check will be conducted by school site staff and/or SDUSD School Police Services. Volunteer assignments may be terminated if service is unsatisfactory or no longer needed by the school district. You may not volunteer if you are required to register as a sex offender under California law.

I give my permission to have my personal and professional references researched and hold the district and any individuals providing the district with information harmless. By signing my name below, I declare under penalty of perjury, that all the information on this application is true and correct. I also declare that I have read and agree to follow the "Volunteer Code of Conduct."

Volunteer Signature: _____ Date: _____

TO BE COMPLETED BY VOLUNTEER COORDINATOR:

TB test completed (Date): _____

Volunteer category (check appropriate box and indicate date cleared):

☐ Category B ✦Megan's Law database check - cleared _____

☐ Category C ✦ SDUSD School Police background check – cleared _____

☐ Category D ✦Fingerprinting – cleared _____

Type of volunteer (check if appropriate):

_____Parent ____OASIS Volunteer
_____Community ____Rolling Reader/EAR ____ CalWORKS
_____Partner ____College Student ____Other _____

Volunteer service ended (date): _____
Reason for leaving:
____Child no longer at school
____ Moved ____Illness
____ Employment ____ Requested to Leave
____ Other: _____

VOLUNTEER APPLICATIONS SHOULD BE FILED AT THE SCHOOL SITE WITH TB AND BACKGROUND CLEARANCE DOCUMENTATION AND SAVED FOR 3 YEARS

California School Employee Tuberculosis (TB) Risk Assessment Questionnaire

(for pre-K, K-12 schools and community college employees, volunteers and contractors)

- Use of this questionnaire is required by California Education Code sections 49406 and 87408.6, and Health and Safety Code sections 1597.055 and 121525-121555.^
- The purpose of this tool is to identify adults with infectious tuberculosis (TB) to prevent them from spreading disease.
- Do not repeat testing unless there are new risk factors since the last negative test.
- Do not treat for latent TB infection (LTBI) until active TB disease has been excluded:
  For individuals with signs or symptoms of TB disease or abnormal chest x-ray consistent with TB disease, evaluate for active TB disease with a chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative tuberculin skin test (TST) or interferon gamma release assay (IGRA) does not rule out active TB disease.

Employee Name: _____ Employee ID: _____

Assessment Date: _____ Date of Birth: _____

History of Tuberculosis Disease or Infection (Check appropriate box below)
◯ Yes • If there is a documented history of positive TB test or TB disease, then a symptom review and chest x-ray (if none performed in the previous 6 months) should be performed at initial hire by a physician, physician assistant, or nurse practitioner. If the x-ray does not have evidence of TB, the person is no longer required to submit to a TB risk assessment or repeat chest x-rays.
◯ No (Assess for Risk Factors for Tuberculosis using box below)

TB testing is recommended if any of the 3 boxes below are checked
☐ One or more sign(s) or symptom(s) of TB disease • TB symptoms include prolonged cough, coughing up blood, fever, night sweats, weight loss, or excessive fatigue.
☐ Birth, travel, or residence in a country with an elevated TB rate for at least 1 month • Includes countries other than the United States, Canada, Australia, New Zealand, or Western and North European countries. • Interferon gamma release assay (IGRA) is preferred over tuberculin skin test (TST) for non-US-born persons.
☐ Close contact to someone with infectious TB disease during lifetime
Treat for LTBI if TB test result is positive and active TB disease is ruled out

^The law requires that a health care provider administer this questionnaire. A health care provider, as defined for this purpose, is any organization, facility, institution or person licensed, certified or otherwise authorized or permitted by state law to deliver or furnish health services. The Certificate of Completion (below) should be completed after screening is completed.

Certificate of Completion

To satisfy job-related requirements in the California Education Code, Sections 49406 and 87408.6 and the California Health and Safety Code, Sections 1597.055, 121525, 121545 and 121555.

The above named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.

Assessment Date: _____

Health Care Provider completing assessment or examination signature: _____

Please print, place label or stamp with Health Care Provider name and address (include number, street, city, state and zip code):

Please return to the Human Resources Division: 4100 Normal St., Room 1241 San Diego, CA 92103: tb@sandi.net: Questions: 619-725-8089