Mount Sinai

The Mount Sinai Medical Center Medical Screening for Observers

In order to protect the health and safety of our patients, staff and visitors with signs or symptoms of communicable disease are restricted from The Mount Sinai Medical Center patient care areas, unless the staff member or visitor is there to seek medical care. Visitors to these areas of the Medical Center are asked to read (or have read to them) this form and to sign below in order to indicate that they understand these restrictions and that they are free of signs and symptoms of communicable diseases.

OR Observer/Visitor Attestation:

To my knowledge, I do not have any communicable (infectious) diseases that can be transmitted from person-to-person by the respiratory route (e.g., during coughing, sneezing, talking) or by casual contact. Such diseases include, but are not limited to: tuberculosis, influenza, pertussis ("whooping cough"), chickenpox, and measles.

In addition, I attest that I have had none of the following symptoms within the past 48 hours:

- Fever
- Chills
- Night sweats
- Cough
- Sore throat
- Runny nose
- Conjunctivitis ("pink eye")
- Vomiting
- Diarrhea
- Rash that is either known to be infectious oi' of an un1‹nown/undiagnosed cause

Signature of Observer/Visitor: _____

Printed name of Observer/Visitor: _____

Company Name (if applicable)/Reason for Visit: _____

Signature of Physician inviting the observer: _____

Department/Division: _____

Date: _____

Mount Sinai

Department of Volunteer Services

Mount Sinai Health System
One Gustave L. Levy, Box 1274
New York, NY 10029-6574

Release Form
Permission for Health Screening For a Minor

I hereby give consent to physicians or licensed Employee Health Services practitioners of the Mount Sinai Health System to perform all aspects of the volunteer service health screening which includes: toxicology screening; history and physical, and skin and blood tests for various communicable diseases (tuberculosis, syphilis, rubella, measles, mumps, varicella, and hepatitis B), and permit the administration of such treatments, procedures, tests (and/or x-rays) as part of the health screening, or as needed in the course of examination, and to treat my child, _____, during the course of his/her volunteer service.

I waive all claim to notification prior thereto and release the Mount Sinai Health System, its physicians, practitioners, nurses and attendants from any and all claims which I may have or may hereafter have in connection with or as a result of any treatment, procedure, test (and/or x-rays) administered.

Name of Minor	
Parent/ Guardian Name (Printed)	
Signature of Parent/ Guardian	Date
Signature of Witness	Date