Volunteer File Checklist-Center

Name of Volunteer: ____________________________ Start Date: __________

Rule .0102(51) "Volunteer" means a person who works in a child care facility and is not counted in staff/child ratio, does not have unsupervised contact with children, and is not monetarily compensated by the facility.

The following items must be present in each volunteer’s personnel file:

<table>
<thead>
<tr>
<th>Item</th>
<th>Due Date</th>
<th>Date Received/ Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Verification of Age (Must be at least 13) (Example: Driver’s License or Birth Certificate)</td>
<td>On or before the first day of work</td>
<td></td>
</tr>
<tr>
<td>TB Screening or Test Results* (Required if volunteer more than once per week)</td>
<td>Prior to the first day of work</td>
<td></td>
</tr>
<tr>
<td>Emergency Information Form</td>
<td>On or before the first day of work, as changes occur, &amp; annually</td>
<td></td>
</tr>
<tr>
<td>Health Questionnaire*</td>
<td>On or before the first day, as changes occur, &amp; annually</td>
<td></td>
</tr>
<tr>
<td>Documentation of being informed of EPR plan and its location.</td>
<td>Day 1 &amp; annually</td>
<td></td>
</tr>
</tbody>
</table>

The items marked with * must be kept confidential and in a separate individual medical file

7/2019
STUDENT WORKERS/VOLUNTEERS/OBSERVERS FORM

Student workers/volunteers/observers attire should be practical while reflecting an attitude of pride and professionalism. Student workers/volunteers/observers are encouraged to dress comfortably; recognizing that work in an early childhood environment requires unhindered freedom of movement and is frequently messy.

ATTIRE REQUIREMENT

- NO HALTER TOPS OR BARE MIDRIFFS
- NO BACKLESS OR STRAPLESS TOP OR DRESSES
- SHORTS, SKIRTS, AND DRESSES SHOULD BE ADEQUATE LENGTH TO ENSURE COVERAGE WHEN MOVING AND BENDING (KNEE LENGTH).
- SHOES MUST BE STURDY AND LOW-HEELED
- FLIP-FLOPS ARE NOT ALLOWED
- NO PANTS BELOW THE WAIST
- NO RIPPED AND/OR TORN PANTS AND/OR SHORTS
- NO PIERCING EXCEPT IN YOUR EARS

STUDENT WORKERS/VOLUNTEERS/OBSERVERS' JOB DESCRIPTION

- Time sheets must be signed daily by classroom teachers, "NO EXCEPTION"
- Wash tables before and after breakfast, lunch and snack
- Sweep floors after breakfast, lunch and snack
- Interact with children in the centers and outside
- Check classroom bathroom, flush toilet, sweep floors when needed
- Greet families and make them aware of who you are
- Help teachers prepare for naptime; put cots in designated area
- Fold sheets, tie shoes when families come during naptime
- When setting tables for breakfast, lunch, and snack always wash hands and wear plastic gloves when serving food
- Greet families and make them aware of who you are
- AND ALL OTHER DUTIES ASSIGNED....
- All Cell Phones MUST be turned in to the front office.
- NO SLEEPING ON THE JOB!

Proud to be......

Gloria Moore-Carter, Director
ECLC Family

Name Print: ________________________________

Signature: ________________________________

Date: ________________________________
Health Questionnaire – Child Care Centers
10A NCAC 09 .0701(a)

All staff, including the director, must complete a health questionnaire annually following the initial medical report. Substitute providers and volunteers must complete a health questionnaire on or before the first day of work and annually thereafter.

| Full name of individual: |
| Home address: |
| Phone number: | Email: |

I certify that I am emotionally and physically fit to care for children.

| Signature: |
| Date: |

***This portion of the form to be completed by the Child Care Center Director***

As the director, I understand that I may request another evaluation of a staff member’s emotional and physical fitness to care for children when there is reason to believe that there has been deterioration in the staff member’s emotional or physical fitness to care for children. This request may be made based upon factors such as observations of myself or other staff members, reports of concern from family, reports from law enforcement, or reports from medical personal. Child Care Rule 10A NCAC 09 .0701(b).

| Director’s Signature: |
| Date: |

*This information must be included in the staff member’s medical file, which must be maintained separately from the staff member’s individual personnel file in the center. Child Care Rule 10A NCAC 09 .0701(d)
Child care providers, including the director, uncompensated providers, substitute providers, and volunteers must provide this information on or before the first day of work. Emergency information must be updated as changes occur and at least annually.

<table>
<thead>
<tr>
<th>Date completed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Full name of individual:</td>
</tr>
<tr>
<td>Home address:</td>
</tr>
<tr>
<td>Phone number:</td>
</tr>
</tbody>
</table>

**Person(s) to be contacted in case of an emergency:**

- **Primary contact**
  
  - Name:
  
  - Address:
  
  - Phone number:

- **Secondary contact**
  
  - Name:
  
  - Address:
  
  - Phone number:

**Choice of health care professional:**

- Address:

- Telephone number:
Tuberculosis Screening Form

10A NCAC 09 .0701 (a) (Centers); .1702 (b)(4) and .1729 (a)(5) & (b) (Family Child Care Homes)

This questionnaire must be administered to all child care providers, by a licensed health care professional, before coming into contact with children. Directors, operators, additional caregivers, substitutes, and individuals who volunteer more than once a week must be screened. Testing should only be performed if the individual answers “yes” to one of the screening questions. Both screening and testing are available at the local health department.

Note to health care professionals: A negative risk and symptom screen should be considered a negative tuberculosis test in such individuals, and no further testing is required. An Interferon Gamma Release Assay is preferred over a tuberculin skin test for otherwise low-risk individuals with a positive response to the risk or symptom screening questionnaires. (See page 2.)

<table>
<thead>
<tr>
<th>Last name (print clearly)</th>
<th>First name</th>
<th>Middle</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tr>
</tbody>
</table>

### Tuberculosis Risk Questionnaire

1) Were you born outside the USA in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe?  
   - YES  
   - NO  

2) Have you traveled outside the USA and lived for more than one month in one of the following parts of the world: Africa, Asia, Central America, South America, or Eastern Europe?  
   - YES  
   - NO  

3) Do you have a compromised immune system such as from any of the following conditions: HIV/AIDS, organ or bone marrow transplantation, diabetes, immunosuppressive medicines (e.g. prednisone, Remicade), leukemia, lymphoma, cancer of the head or neck, gastrectomy or jejunual bypass, end-stage renal disease (on dialysis), or silicosis?  
   - YES  
   - NO  

4) Have you ever done one of the following: used crack cocaine, injected illegal drugs, worked or resided in jail or prison, worked or resided at a homeless shelter, or worked as a healthcare worker in direct contact with patients?  
   - YES  
   - NO  

5) Have you ever been exposed to anyone with infectious tuberculosis?  
   - YES  
   - NO  

### Tuberculosis Symptom Questionnaire

Do you currently have any of the following symptoms?

1) Unexplained cough lasting more than 3 weeks?  
   - YES  
   - NO  

2) Unexplained fever lasting more than 3 weeks?  
   - YES  
   - NO  

3) Night sweats (sweating that leaves the bedclothes and sheets wet)?  
   - YES  
   - NO  

4) Shortness of breath?  
   - YES  
   - NO  

5) Chest pain?  
   - YES  
   - NO  

6) Unintentional weight loss?  
   - YES  
   - NO  

7) Unexplained fatigue (very tired for no reason)?  
   - YES  
   - NO  

The above health statement is accurate to the best of my knowledge. I will contact my health care professional and/or the health department if my health status changes.

Signature:            Date:

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Screening administered by licensed health care professional:

Printed name and location:

Signature:            Date:

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*This information must be included in the operator or staff member’s medical file, which must be maintained separately from the operator or staff member’s individual personnel file that is kept on site.*
# Tuberculosis Testing Form

10A NCAC 09 .0701 (a) (Centers); .1702 (b)(4) and .1729 (a)(5) & (b) (Family Child Care Homes)

## Record of Tuberculosis Test

<table>
<thead>
<tr>
<th>Last name (print clearly)</th>
<th>First name</th>
<th>Middle</th>
<th>Date of birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Type of test:

- [ ] Tuberculin
  - Date given: __________________________
  - Date read: __________________________
  - Results: MM reading: __________
  - [ ] Negative
  - [ ] Positive

- [ ] Interferon Gamma Release Assay
  - Date: __________________________
  - Results: __________________________

### Comments:

[ ]

### Signature of Authorized Health Professional

<table>
<thead>
<tr>
<th>Signature of Authorized Health Professional</th>
<th>Date</th>
<th>Location</th>
</tr>
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The North Carolina Child Care Health and Safety Resource Center  
NC DHHS DPH - Communicable Disease Branch and DCDEE  
Updated June 2019