RurAL CAP

Elder Mentor / Foster Grandparent Program

Volunteer Health Assessment

Volunteer Name: _____ Date of Birth: _____

Healthcare Provider Name:_____ Fax:_____

I authorize my healthcare provider to release the information requested below to determine my ability to participate in the Foster Grand Parent/Elder Mentor program. This information will be updated annually. I understand that my personal health insurance will be billed for any provider charges incurred for this assessment. RurAL CAP will pay up to $100.00 towards any provider fees not covered by my personal insurance.

_____ _____

Volunteer Signature Date

Foster Grandparents and Elder Mentors work approximately 20 hours per week in the school setting. Their activities may include reading, helping with assignments, storytelling, holding or carrying small children, and accompanying children on outings.

Based on the health assessment conducted, _____:

Volunteer Name

☐ Is able to participate in the activities above with no restrictions.

☐ Is able to participate in the activities above with the following restrictions:

_____

_____

☐ Is not able to participate in the activities above.

Date of last assessment/exam: _____

_____ _____

Printed name of healthcare provider Title

_____ _____

Signature Date

Please fax completed document to:

RurAL CAP Foster Grandparent Program
Confidential Fax: 866-287-7053
Phone: 907-865-7276 or Toll-free: 800-478-7227