



**Unity Health Care, Inc.**  
**PPD Parental/Guardian Consent**  
**(This consent must be submitted with copy of photo identification)**

I, \_\_\_\_\_, the parent or legal guardian of \_\_\_\_\_, volunteer, who is \_\_\_\_\_ years of age, hereby give permission for Unity Health Care, Inc. to administer a PPD (Tuberculosis) test on said child, so that he/she can volunteer with Unity Health Care, Inc. I am aware that the test is a requirement in order to volunteer at any Unity Health Care, Inc. location. I understand that the test is a two-day process and that said child would need to return within 48 to 72 hours to have the test results read.

\_\_\_\_\_  
Name of Volunteer

\_\_\_\_\_  
Print Name of Parent/Guardian

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date