Teenage Volunteer Application

NAME____DATE__________
(Last) (First) (Middle)

ADDRESS____

CITY___________________________STATE_____________ZIP__________________

HOME PHONE___________WORK PHONE_______________
(if applicable)

AGE ______________ BIRTH DATE_______________

IF PRESENTLY EMPLOYED, NAME OF FIRM________________________________

POSITION__________________________ WORK HOURS & DAYS______________

PARENT/GUARDIAN____

CONTACT IN CASE OF EMERGENCY:

____
(NAME) (RELATIONSHIP) (HOME PHONE) (WORK PHONE)

FAMILY PHYSICIAN______________________________PHONE________________

LIMITATIONS RELATED TO HEALTH_____________________________________

HOW DID YOU BECOME INTERESTED IN OUR VOLUNTEER PROGRAM?

____

AT WHAT TIMES ARE YOU AVAILABLE TO VOLUNTEER?

DAY____________________ A.M._________________P.M.__________________

HAVE YOU VOLUNTEERED FOR THIS ORGANIZATION BEFORE? YES__NO___

EDUCATION- CURRENT GRADE ___________GRADE POINT AVERAGE______

PROJECTED YEAR OF GRADUATION FROM HIGH SCHOOL _________________

VOLUNTEER EXPERIENCE____

WORK EXPERIENCE____

INDICATE HOBBIES/SKILLS/SPECIAL INTERSTS/FOREIGN OR SIGN LANGUAGE SKILLS:____

References:
Personal or Professional References (Please exclude relatives)
1. Name_______________________________________ Phone_________________

Address______________________City_______________State________Zip ______

2. Name ______________________________________Phone________________

Address ______________________ City_______________State________Zip_______

Skills & Training: (Please indicate with a check mark which you would be willing to share as a volunteer here)

Clerical Skills:___typing ___filing ___phone receptionist ___ using copier ___librarian ___record updating numerical updating___computer___mailings___alphabetizing ___cash register___other (specify:_____)

Communication Skills: ___public speaking ___journalism ___public relations ___research ___photography calligraphy____foreign language ___graphic arts ___other (specify:_______)

Patient Cares Services (as applicable to the organization): ______infant/child care ______escort service, transport _____messenger service ___read to patients ___visiting, listening ___patient consolation ___other (specify:______)

Personal Skills to Use or Teach: ____drawing _____painting ____knitting ____crocheting ____macrame sewing____crafts ___needlework ___leather work ___gardening ___baking ___special event host ___repair person___musical instrument (specify:__________)

Additional Skills/Comments:____

Agreement: (please read carefully)
In making application to become a Winter Haven Hospital volunteer, I agree to abide by the Policies and Procedures of the Hospital, the Dress Code and the Code of Ethics. I will keep all patient information completely confidential. I know that I must complete the Health Screening process, attend Orientation, complete four training sessions, strictly adhere to my service guidelines and accurately record my service hours.

I understand that the organization is not obligated to provide a placement, nor am I obligated to accept the position offered. I understand if I am accepted into the Volunteer Program I will be in an evaluation process for a six week period or until all requirements of active volunteer status are completed. Further, I agree to return my photo ID badge in the event I do not complete membership requirements or when I leave the program.

Qualified applications will be considered without regard to race, color, sex, religion, age, national origin, disability or marital status.

Signature____Date___________

For office use only:

Date application received:____________Interviewed by:___________________________Date:________
ID Badge issued:___________Orientation Part I/Part II date(s)________Health Screening : ___________
90 day follow up:_____________

WINTER HAVEN HOSPITAL, INC.
VOLUNTEER SERVICES
200 Avenue F, N.E.
Winter Haven, Florida

PARENT/GUARDIAN CONSENT FOR PARTICIPATION IN TEEN-AGE VOLUNTEER PROGRAM

DATE_______________

I hereby state that my son/daughter is age ______, and give my consent for him/her to serve as a Volunteer in the Teen-Age Volunteer Program at the Winter Haven Hospital. I will read the list of rules and regulations concerning the TAV Program and discuss them with my son/daughter.

Each member is required to contribute one service assignment per week.

Parent/Guardian Signature

____

Applicant Signature

____

PARENT/GUARDIAN CONSENT FOR HEALTH SCREENING PROCESS

I voluntarily give permission for my child, ______________________, to be medically screened as a part of the Teen Volunteer Program at Winter Haven Hospital. I understand the process will involve:

1. Completion of a health history questionnaire
2. Measurement of blood pressure and pulse rate
3. Gross visual acuity test
4. Assessment of immunity status for common communicable diseases including measles, rubella, chicken pox and tuberculosis
5. Administration of a skin test for TB(PPD) if last test more than 12 months ago as verified by records*

I understand that proof of immunization is required by WHH Infection Control Policy as well as Federal and State public health laws, and must be provided at my cost (except for PPD testing). To facilitate this I will need to provide copies or my child's shot records and indicate below on this form whether my child has had the chicken pox. The records will be reviewed by the Occupational Health Nurse. Any deficiency will be communicated.

I understand that is my child cannot show immunity and does not receive the required vaccines for any reason, they **cannot** participate in the TAV program.

______ My child _______________________ has had the chicken pox.

______ No, my child ______________________ has not had the chicken pox.

____

Parent/ Guardian Signature Date

____

Witness (Representative of TAV Program, Occupational Health or Notary Public only!)

____

*I hereby give permission for my child to receive a skin test for tuberculosis (PPD) to be administered and interpreted by the Occupational Health Nurse at WHH. I understand that this test is required every 12 months by WHH policy. In some highly sensitive persons, strong positive reactions may cause redness, swelling, soreness, vesiculation or ulceration at the actual test site. I understand that I may also have this test done by the physician of my choice, at my expense, and then furnish proof of testing to the Occupational Health Office.

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Parent/Guardian Signature Date