

McLeod Health

The Choice for Medical Excellence

Junior Volunteer Application

TO BE COMPLETED BY APPLICANT

Name _____ Phone Number _____

Address _____ City _____ State _____ Zip Code _____

Email Address _____

Date of Birth _____ Age _____ Social Security Number _____

What school do you attend? _____ Grade _____

List school and church activities _____

Please list honors and awards you have received at your school and/or church _____

Have you ever volunteered before? Yes/No If yes, where and what did you do? _____

Are you interested in a health related career? Yes/No if so, what are your interests? _____

TO BE COMPLETED BY PARENT OR GUARDIAN

Name _____ Phone Number _____

Address (If different from applicant) _____

Employer _____ Work Phone Number _____

In case of emergency, we would notify _____

Phone Number _____ Relationship _____

PARENTAL AGREEMENT

I/We the parents of _____, join with our teen in consenting to his/her participation in the McLeod Health Clarendon Teen Volunteer Program. This program will be under the leadership and guidance of the Volunteer Services Department.

Parent Signature _____ Date _____

_____ Date _____

JUNIOR VOLUNTEER AGREEMENT

As a teen volunteer, I understand that confidentiality is not only important, but required. Any teen who releases any patient information will be released immediately from the program. I understand that under the HIPPA Regulations, teen volunteers are personally liable under Federal Law to know and follow our confidentiality policy. I will be instructed in the values and mission of the medical center and my behavior will always reflect these values.

Junior Applicant Signature _____ Date _____

HEALTH INFORMATION

Have you had Chicken Pox? Yes _____ No _____

Have you had the flu vaccine? Yes _____ No _____ (if yes, please provide copy of vaccination)

Have you had MMR (measles, mumps, and rubella) vaccine in the last three years? Yes _____ No _____

If yes, when? _____

Do you have any limitations which may require special work assignment? Yes _____ No _____

If yes, please give details _____

Are you taking medication on a regular basis? Yes _____ No _____

Please list medications _____

Name of your personal physician _____ Phone _____