To: Prospective Teen Volunteers

Thank you so much for showing interest in the 2012 Teen Volunteer Summer Program at USA Children's & Women's Hospital. Throughout the summer, teen volunteers provide valuable service to our patients, visitors and staff while enjoying a unique opportunity for personal growth and satisfaction. Teen volunteers serve throughout the hospital in patient and non-patient care areas, seven days a week. The minimum age to volunteer is 14 years old.

If you are interested in volunteering at USA Children's & Women's Hospital this summer, we encourage you to apply as soon as possible. Only 50 teens will be accepted into the program. This includes **new and returning** teens. Selection is based on the date we receive your **COMPLETED** information.

The 2012 Teen Volunteer Summer Program Application includes:

- 2012 Teen Volunteer Summer Program Application Checklist
- Volunteer Application
- Volunteer Health Assessment
- 2 Recommendation Forms

Additional documents you must submit:

- Copy of Driver's License or school I.D.
- Current report card showing 2.5 GPA
- Copy of Immunization Record
- Documentation of Tuberculosis (TB) Skin Test within the past 12 months

All information must be submitted to the Volunteer Services Office by April 30, 2012. Once we receive your **COMPLETED** information you will be invited to orientation. Attendance is MANDATORY. If you are unable to attend orientation, your spot in our program will be given to another volunteer applicant.

Reminder: The 2012 summer session is from June 4 – July 27, 2012 (8 weeks). Since this is such a short time period we ask everyone to commit to volunteer a 4 hour shift each week for the entire 8 weeks. No make-up days will be offered.

Dates to remember:
April 30: Deadline to submit volunteer application
May 12 and May 19 from 9am – 11am: Teen Volunteer Orientation
June 4: Teen Summer Program begins
July 27: Teen Summer Program ends & Teen Summer Volunteer Party @ Paint Party Studio

If you have questions, please feel free to call our office at (251)415-1123.
Ally deVeer or Belinda Baggett can help.

We look forward to hearing from you soon.

Sincerely,

Volunteer Services Team

Mail forms to: USACWH Volunteer Services, 1700 Center Street, Mobile, AL 36604

2012 Teen Volunteer Summer Program
Application Check Sheet

This packet includes:

[ ] Volunteer Application (2 pages)

[ ] Volunteer Health Assessment (2 pages)

[ ] 2 Recommendation Forms (cannot be completed by family member or friend)

Additional documents that must be submitted:

[ ] Copy of Driver's License; school I.D. for teen volunteers

[ ] Copy of Immunization Record

[ ] Current Grade Report showing a 2.5 GPA (teen volunteers only)

[ ] Documentation of Tuberculosis (TB) Skin Test within the past 12 months

Please send **COMPLETED** Volunteer Applications to:

USA Children's & Women's Hospital
ATTN: Volunteer Services
1700 Center Street
Mobile, AL 36604-3301

If you have any questions please call our office at (251) 415-1123.

USA Children's & Women's Hospital
Volunteer Application

Please mark appropriate type of volunteer: __________ Adult __________ College Student _________Teenage (age 14 -18)

First Name_______________________________________Middle___________________Last_______________________________

Street address____City________________________State_____Zip_________

Home Phone_______________________________Work_________________________________Cell_________________________

Birth Date _______ /_______ /________ Soc. Sec. #__________________________ email__________________________________

Emergency Contact Name____________________________________Relationship_________________Day Phone______________

If a minor, parent/guardian names_____________________________________Relationship_______________Phone_____________

Circle highest level of education completed**:** High School: 9 10 11 12 College: 1 2 3 4 + Degree:__________________

If college or high school student, name/city of school you attend____

Have you volunteered/worked at USA (hospitals, clinics or campus) before? Yes No Dates______/______ to_______/_______

If so, where? ____

Do you have family members employed at USA? yes no If so, relative's name/department______________________________

Why do you want to volunteer and what do you hope to gain by this experience?

VOLUNTEER EXPERIENCE	Agency Name (current first)	Dates	Title/Duties
1.	______________________________	________	__________________
2.	______________________________	________	__________________
3.	______________________________	________	__________________

WORK EXPERIENCE	Name of Employer (current first)	Dates	Title/Duties
1.	______________________________	________	__________________
2.	______________________________	________	__________________
3.	______________________________	________	__________________

Community or Service Organization affiliation:

Have you ever been convicted of a crime (felony or misdemeanor, including DUI)? yes no If yes, please explain:

Placement Preference: _____ Patient Care Area _____ Non Patient Care Area Particular area?__________________________

Circle day(s): SU M T W TH F SA Time(s) available :____________________ When would you like to begin? ______________

Please return all pages of application to:

USACWH Department of Volunteer Services
1700 Center Street ▪ Mobile, Alabama 36604
(251) 415-1123 ▪ (251) 415-1122 *fax*

ACKNOWLEDGEMENTS & CONFIDENTIALITY PLEDGE

The information I provided for this application is accurate and correct to the best of my knowledge. I approve USACWH to check references. USACWH is not obligated to provide a volunteer placement, nor am I obligated to accept the placement offered. Opportunities for volunteering are provided without regard to religion, creed, race, national origin, age or sex.

I recognize the necessity of maintaining the confidentiality of all data and documents collected and processed by USACWH. Confidential information is defined as proprietary business data or information which contains identifying information which can be linked to a specific individual or patient. I also recognize the importance of my part in assuring the right to privacy of persons and institutions cooperating with this facility. I further understand that this facility has both ethical and legal responsibilities to safeguard confidential information. Therefore, I will not divulge any confidential information I may encounter while volunteering at USACWH. Further, I will not make any copy of or transport off the premises any confidential information. I am aware, that in some instances, civil and criminal penalties are possible if unauthorized disclosure of confidential research records and data occurs. I agree to accept any liability which may accrue to this facility for any breaches of confidentiality which occur through my direct action.

I HEREBY AGREE THAT I WILL ABIDE BY THE POLICIES OF USACWH. I UNDERSTAND THAT IF I VIOLATE ANY OF THESE POLICIES, I MAY BE DISMISSED FROM THE VOLUNTEER PROGRAM. I HAVE CONSIDERED THE SERIOUSNESS OF THE COMMITMENT I AM MAKING AS A VOLUNTEER.

Applicant's Name: ______________________________

Signature: ______________________________ Date: ______________

(If applicant is under 19 years of age, parent/legal guardian must sign also).
Parent/Legal Guardian's Signature: ______________________________ Date: ______________

RELEASE FROM LIABILITY

TO THE UNIVERSITY OF SOUTH ALABAMA: I, ______________________________
understand that I will be voluntarily participating in the Volunteer Program at USACWH. In consideration of the University of South Alabama permitting me to participate in this activity, I, in full recognition and appreciation of any and all risks, hazards, or dangers, if any, inherent in this activity, to which I may be exposed, do hereby agree to assume all of the risks and responsibilities surrounding participation in such activity.

I do for myself, my heirs and personal representatives, hereby defend, hold harmless and indemnify, release and forever discharge the University of South Alabama, its trustees, officers, agents, servants and employees from and against any and all claims, demands and actions or causes of action on account of or resulting from my participation in this activity and/or which may result from causes beyond the control of, and without the fault or negligence of the University of South Alabama, its trustees, officers, agents, servants and employees, during the period of participation as aforesaid.

I fully understand the risks involved in this activity and agree to assume those risks. I understand that the University of South Alabama, its trustees, officers, agents, servants and employees assume and accept no liability for wages of any kind, personal injury or loss of life or damage to personal property.

IN WITNESS WHEREOF, I have caused this release to be signed this ______ day of ________, 20 ____.

PRINTED NAME OF VOLUNTEER	PRINTED NAME OF WITNESS
SIGNATURE OF VOLUNTEER	SIGNATURE OF WITNESS
PRINTED NAME OF PARENT/GUARDIAN	PRINTED NAME OF WITNESS
SIGNATURE OF PARENT/GUARDIAN	SIGNATURE OF WITNESS

Parent/guardian phone__________________________ *or* next of kin name ______________________phone ___________________.

VOLUNTEER HEALTH ASSESSMENT

First Name_______________ Middle_______________ Last_______________

Street address_______________ City_______________ State_____ Zip_________

Birth Date ______ /______ /_______ ☐male ☐female Phone_______________

Your primary physician's name: _______________

Address: _______________

Do you have any food, drug or environmental allergies? ☐yes ☐no

I am allergic to:

Are you presently under a doctor's care for any condition? ☐yes ☐no

I am being treated for:

Are you currently taking any medications? ☐yes ☐no

My current medications are:

Do you suffer from or are you susceptible to any immunity disorder? ☐yes ☐no

Have you ever had a positive TB skin test? ☐yes ☐no

Vaccination		**Date(s) Immunized**	**Comments**
Hepatitis B	☐yes ☐no		
MMR	☐yes ☐no		
Tetanus	☐yes ☐no		
Medical History		**Date(s)** *when you have/had or received treatment for condition*	**Comments**
Diabetes	☐yes ☐no		
Back Pain, Injury, Strain, Sprain	☐yes ☐no		
Knee, Leg or Foot Trouble	☐yes ☐no		
Asthma, Hay Fever, Sinus Trouble	☐yes ☐no		
Deafness or Impaired Hearing	☐yes ☐no		
Dizziness or Fainting Spells	☐yes ☐no		
Seizures or Epilepsy	☐yes ☐no		
Mental or Nervous Disorder	☐yes ☐no		
Chickenpox Hx/Vaccine	☐yes ☐no		
Measles/Rubella	☐yes ☐no		
Mumps	☐yes ☐no		
Other			

To the best of my knowledge, this information is correct. I understand that falsification of this information is grounds for dismissal.

Volunteer Name/Signature _______________ Date _________

Guardian's Name/Signature: _______________ Date _________

Section to be completed by USACWH Staff:

Weight__________ Height__________ BP__________ Pulse__________ Color Blind: ☐yes ☐no

Reviewed health history and all health requirements have been met.

Cleared to begin volunteering by: _______________ Date__________

Volunteer Health Requirements:
Copy of Immunizations Record (blue card): Immunizations/immunity to: **Measles/Mumps/Rubella-** 2 doses; 1 dose if born prior 1957
2-step Tuberculosis (TB) testing with PPD is required. Documentation of a TB skin test within the past 12 months is REQUIRED. You will need to get a 2nd test, available *free* through the hospital, after you complete orientation. If you have had BCG in the past, you are not exempt from this policy unless you have had a positive PPD and can provide documentation (copy of medical documentation of positive PPD report, report of your chest x-ray and a copy of your evaluation for TB prevention including any medical treatment you received). You should not have further TB testing. USACWH staff will conduct a symptom check instead of a TB test.
History chicken pox declaration or documentation of immunity to chicken pox by titer, or by having had chicken pox vaccine (we require 2 vaccinations). If you have not had chicken pox in the past nor had chicken pox vaccine, you may go to your physician and get a titer.
Hepatitis B immunizations may be required in some situations if there is a possibility the volunteer may be exposed to blood/body fluids. Our hospital does not provide Hep B series to volunteers. Please consult your medical provider.

INFORMATION ABOUT HEPATITIS B VACCINE

THE DISEASE: Hepatitis B is a viral infection caused by Hepatitis B virus (HBV), which causes death in 1% to 2% of patients. Hospital workers with frequent exposure to blood and needles have a higher risk of contracting Hepatitis B. Most people with Hepatitis B recover completely, but approximately 5% to 10% become chronic carriers of the virus. Most of these people have no symptoms, but can continue to transmit the disease to others. Some may develop Chronic Active Hepatitis and Cirrhosis. HBV also appears to be a causative factor in the development of liver cancer. Thus, immunization against Hepatitis B can prevent acute Hepatitis and also reduce sickness and death from Chronic Active Hepatitis, Cirrhosis, and Liver Cancer.
THE VACCINE: Hepatitis B vaccine is free of association with human blood or blood products. It has been extensively tested for safety in chimpanzees and for safety and efficacy in large-scale clinical trials with human subjects. A high percentage of healthy people who receive 3 doses of vaccine achieve high levels of surface antibody (anti-HBs) and protection against Hepatitis B. Persons with immune system abnormalities, such as dialysis patients, have less response to the vaccine, but over half of those receiving it do develop antibodies. Full immunization requires three doses of vaccine over a six-month period although some persons may not develop immunity even after three doses. There is no evidence that the vaccine has ever caused Hepatitis B; however, persons who have been infected with the HBV prior to receiving the vaccine may go on to develop clinical Hepatitis in spite of immunization. The duration of immunity is unknown at this time. The vaccine will not prevent Hepatitis by non-Hepatitis B viruses.
POSSIBLE VACCINE SIDE EFFECTS: The incidence of side effects is very low. No serious side effects have been reported with the vaccine. A few people experience tenderness and redness at the injection site. Low-grade fever may occur. Rash, nausea, joint pain and mild fatigue have also been reported. The possibility exists that more serious side effects may be identified with more extensive use (allergic reactions to vaccines include those with allergies to Baker's yeast and Thimersol).

CONSENT FORM

I have read the above statement about Hepatitis B and the vaccine. I have been provided information regarding Hepatitis B and the Hepatitis Vaccine. I have been given an opportunity to ask questions and understand the benefits and risks of Hepatitis vaccination.

Applicant's Signature: ______________________ Date: __________

(If applicant is under 19 years of age, parent/legal guardian must sign also).
Parent/Legal Guardian's Signature: ______________________ Date: __________

Read statements below and sign the one that applies:
I DO NOT WISH to receive the Hepatitis B Vaccine Series *(which is available through providers, health departments, or clinics).*
I understand that due to my occupational exposure to blood or other potentially infectious materials, I may be at risk of acquiring Hepatitis B virus (HBV) infection. However, I decline Hepatitis B vaccine at this time. I understand that by declining this vaccine, I continue to be at risk of acquiring Hepatitis B, a serious disease. If in the future I continue to have occupational exposure to blood or other potentially infectious materials and I want to be vaccinated with Hepatitis B vaccine, I can receive the vaccination series at my own expense and provide documentation to Volunteer Services.
Applicant's Signature: ______________________ Date: __________

(If applicant is under 19 years of age, parent/legal guardian must sign also).
Parent/Legal Guardian's Signature: ______________________ Date: __________
OR
I have ALREADY RECEIVED the Hepatitis B Vaccine Series.
Applicant's Signature: ______________________ Date: __________

(If applicant is under 19 years of age, parent/legal guardian must sign also).
Parent/Legal Guardian's Signature: ______________________ Date: __________

USA CHILDREN'S & WOMEN'S HOSPITAL

Department of Volunteer Services

Recommendation Form

This form should be completed by a personal/education/professional reference and submitted with your volunteer application. Person completing the form *may not* be a relative. For teens, this form must be completed by school personnel.

Volunteer Applicant's Full Name____

Person giving the reference____

Reference address____

Phone________________________ Relationship to applicant___________________

Would you recommend this individual to volunteer at USA Children's & Women's Hospital? ____Yes _____No

Please describe the applicant's interpersonal relationship skills – how do they get along with people?

Rate the following qualities with A (excellent) B (satisfactory) C (needs attention)

Attitude _____ Dependability _____ Appearance _____

Is there additional information that you would like to share about the applicant?

Reference Signature _______________________________Date _________________

Recommendations should be returned to applicant in a sealed envelop.

Applicant must submit TWO recommendation forms with completed application and health assessment form.

USA CHILDREN'S & WOMEN'S HOSPITAL

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