Children's Hospital of Wisconsin®
A member of Children's Hospital and Health System.
Fox Valley

16-17 year old Volunteer Application Instructions

Please take a moment to read through the following checklist designed to help you complete the application process.

Volunteer Services CANNOT process or review incomplete applications.

COMMITMENT PROMISE:

- Volunteers are asked to commit to two hours of volunteer time per week for a period of at least six months.
- In our promise to keep patients safe, Volunteers will complete all required TB screenings and provide all necessary medical documentation.

STEP ONE: To be completed by volunteer applicant

- ☐ **Completely fill out all 6 pages of the application**- including the Volunteer Health Assessment, Confidentiality Statement and TWO Signed Parent Consent Forms –
  1. Volunteer parental consent
  2. Health and Wellness
- ☐ **Include one letter of reference**. From an employer, teacher, coach or co-worker.
- ☐ **Include a copy** of an **official documentation** of having received **two measles, mumps and rubella (MMR)** immunizations from a Doctor or a Clinic.

STEP TWO: Mail completed application = ALL 8 pages

☐ **Mail completed application to The Volunteer Department – address details on application form.**

STEP THREE: Orientation

- **Invitations to the orientation are sent directly to you by mail if your availability matches a current vacancy.**
- **Information on the Two-step TB screen tests is provided during orientation.**
  - **Volunteers are not permitted to start until both tests are complete and read by validated personnel.**

STEP FOUR: Interview

- **Interviews are scheduled during the orientation. Please bring your calendars.**

PLEASE NOTE:

- Volunteer placements are determined by availability and need within the hospital.
- ***If you do not receive an invitation to orientation, we will keep your application on file for one month. If your availability changes or you want to check for new openings, please call the Volunteer Services Department.***

Thank you for your interest in volunteering at Children's Hospital of Wisconsin – Fox Valley.
We look forward to having you as a member of our team!

High School Volunteer Application

NAME: (last, first, middle initial) **DATE:**

_____ _____

Please print clearly

HOME ADDRESS: **Last 4 digits of your SOCIAL SECURITY # XXX-XX-_____**

Street: _____

City: _____ **State:** _____ **Zip Code:** _____

Home Phone: (_____) _____ **E-mail address:** _____

Please print clearly

Cell phone: (_____) _____ **Date of birth (mm/dd/yy):**____ /_____/_____

AVAILABILITY: Please indicate which day(s) of the week and specific times you would like to volunteer. Example: if you can volunteer on Monday's from 3:30 pm to 6:30 pm, just enter the time in the Monday column. Do the same process for each day of the week. Do not enter anything on the days you are not available to volunteer. **What date can you start?** Please be specific.

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Number of hours you want to volunteer each week._____ **Date available to start**_____

PLEASE NOTE: **If you are volunteering to fulfill a class requirement or to complete service hours, Children's Hospital of Wisconsin Volunteer Program does not guarantee placement or fulfillment of hours.**

EDUCATION:

High School Name: _____ Graduation year: _____

Other education: _____

Please help us learn more about you:

How did you hear about us? _____

Tell us why you selected Children's Hospital as a place to volunteer:

_____

What special skills or talents do you bring to your volunteer placement?

_____

COMMITMENT AGREEMENT: I am willing to commit 2 hours a week to a volunteer placement at Children's Hospital of Wisconsin for a minimum term of 6 consecutive months.

Signed: _____ Date: _____

Please complete other side of application.

High School Volunteer Application

EMPLOYMENT:

Most recent employer: _____ Start date: _____

Address: _____ End Date: _____

City, State, Zip _____ Hours/week: _____

Supervisor & phone: _____ Position: _____

OTHER ACTIVITIES: Including volunteer work (current & past), and any group/community affiliations.

_____

_____

SECONDARY CONTACT (example: family member)

Name: _____ Relationship: _____

Home phone: ( ) _____ Work phone: ( ) _____

Cell phone: ( ) _____

- If I'm offered and accept a volunteer placement at Children's Hospital of Wisconsin, I will commit to at least two hours of service each week for six months. ☐ I agree.
- I agree to have any medical tests and immunizations (example: TB and Measles-Mumps-Rubella) required by Children's Hospital. ☐ I agree.
- I understand that this application does not guarantee a volunteer placement at Children's Hospital. ☐ I understand.
- I certify that the statements made in this application are true and complete.

_____ _____

Signature Date

Please return this application ***with*** one letter of reference* to:

Children's Hospital of Wisconsin - Fox Valley
Community Relations
130 Second Street
West Pavilion, 2nd Floor
Neenah, WI 54956

***Due to the high volume of volunteer applications, if your application is received without a reference letter, it cannot be processed. Please be sure to send both the application and letter of reference together. Thank you.

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Parental Consent Form

We would like to take this opportunity to tell you how pleased we are that your teen has shown an interest in volunteering at Children's Hospital of Wisconsin – Fox Valley. It is a wonderful way to develop a sense of responsibility and commitment. They will get first hand experience learning about the value and rewards of volunteerism.

It is important that both you and your teen understand the importance of their six month commitment to Children's Hospital of Wisconsin – Fox Valley. We ask that they be on time for their weekly assignment and call their department if for any reason they are unable to be here. Please support and assist them in every possible way.

Wisconsin state regulations require parental consent for our minor volunteers. Please take a moment to sign the parental consent form below and have your teen return it with the applications packet. Thank you for your support! If you have any questions, please feel free to call us at (920) 969-5304.

CONSENT FORM

NAME OF MINOR _____
(Please Print)

NAME OF PARENT / LEGAL GUARDIAN _____
(Please Print)

I give my permission for the minor named above to volunteer at Children's Hospital of WI – Fox Valley. This consent is valid and in effect for as long as this minor volunteers at a Children's Hospital and Health System facility, or becomes legally authorized to give own consent.

_____ _____
SIGNATURE **DATE**

Jenny Krikava, Community Relations Coordinator 920.969.5303 jkrikava@chw.org
www.chw.org/foxvalley **Fax Number: (920) 969-7979 Phone Number: (920) 969-5304**

EMPLOYEE HEALTH and WELLNESS CONSENT FOR MINORS

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Children's Hospital and Health System requires the written consent of a parent or a legal guardian for a minor (anyone under 18 years of age) to have an immunization assessment and tuberculosis screening. The parent or legal guardian may ***not*** give telephone permission for the immunization assessment or tuberculosis (TB) screening.

Be sure that your child brings her immunization record to the appointment for the nurse to document and review. It is most important that your child has received two MMR (measles, mumps, rubella) vaccines. If there is no record of having received two vaccines, they will need to be administered by their own medical provider and written documentation faxed/sent to Theda Clark Employee Health and Wellness.

A two-step tuberculosis skin test will be administered. It will be necessary for your child to return to Theda Clark Employee Health and Wellness two to three days after each test is placed, for "reading" of the test site. Please be sure your child brings any documentation that is available regarding previous TB skin testing. A child who has had prior positive tuberculin skin test or currently tests positive will be required to complete a written symptoms survey and have a chest x-ray.
A parent or legal guardian may accompany a minor to his/her appointment.

If you have any questions, please call the Theda Clark Employee Health and Wellness Nurse at (920) 720-7349.

Thank you for your cooperation.

CONSENT FORM

NAME OF MINOR _____
(Please Print)

NAME OF PARENT / LEGAL GUARDIAN _____
(Please Print)

I give my permission for the minor named above to volunteer to have an Immunization Assessment and Tuberculosis Screening, at Theda Clark Employee Health. This consent is valid and in effect for as long as this minor volunteers at a Children's Hospital and Health System facility, or becomes legally authorized to give own consent.

_____ _____
SIGNATURE **DATE**

Volunteer Health Assessment

TO: Volunteer Applicant
FROM: Employee Health and Wellness Children's Hospital of WI
RE: Pre-Volunteer Health Screening

The Wisconsin Department of Health and Social Services requires all hospital volunteers who may have patient contact to complete a health history and provide proof of measles, mumps and rubella immunity or vaccination. If no record exists, a blood test is needed to determine immune status. Children's Hospital may perform this lab work for you. Those individuals lacking immunity must be vaccinated prior to having patient contact.

In addition to the required health documentation you have provided, **please explain any ongoing health problems, communicable diseases and/or any physical, cognitive, or learning limitations** which may require accommodation in order to allow you to perform volunteer duties at Children's Hospital of Wisconsin:

_____

_____

_____

_____

_____

I hereby declare that all statements include in this Health Assessment are true and correct to the best of my knowledge.

Signature: _____ Date: _____

_____ Date: _____

Signature of parent or guardian, if minor

The information you provide will be maintained in your volunteer file and is ***confidential.***
Thank you for your cooperation.

If you are currently under the care of a physician for an ongoing health issue - the following must be completed by a health care practitioner:

➢This patient is free of communicable disease and current with his/her immunizations: **Y N**

As a volunteer, this applicant may be assigned to a patient care area, walk a significant distance, and/or perform light physical duties such as pushing a wheelchair.

This patient may volunteer:
☐ Without restrictions.
☐ With the following restrictions: _____

_____ Date: _____

Signature of physician, Nurse Practioner, or Physician assistant

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www.chw.org/foxvalley **Fax Number: (920) 969-7979 Phone Number: (920) 969-5304**

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Confidentiality Statement of Understanding (Volunteers)

I understand that information contained in medical or electronic records are the property of Children's Hospital and Health System. Therefore, the patient has the right to expect that health records will be managed confidentially. It is the responsibility of Children's Hospital and Health System to protect the confidentiality of such information. I agree to adhere to the following policies and I understand that any violation of these guidelines could result in corrective action up to and including immediate dismissal.

1. Volunteers who are granted access to confidential information are accountable to for the protection of the information.

2. Confidential documents may not be removed from Children's Hospital and Health System except as ordered by judicial process.

3. Employees, physicians, volunteers or other representatives only have the right to access information directly related to patients for whom they are providing care or services.

4. Access to written, electronic or verbal information about family, friends, fellow employees or acquaintances is prohibited.

5. Uniform and photo identification are issued on the day a volunteer begins and are to be returned to the volunteer office on the last day of service.

Volunteer Name (Please print): _____

Volunteer Signature: _____

Date: _____

Confidentiality Statement.doc
Revised 7/31/06

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