Volunteer Services
High School Application Instructions

*****Please remember you must be 16 years or older to apply*****

Thank you for your interest in volunteering at Children's Hospital of Wisconsin.

Children's Hospital of Wisconsin is very appreciative of the great community interest in helping children and families. Our program opportunities are based on the service needs of the hospital; therefore we match applicant's skills, availability and experience to our current needs.

If your application is complete and meets our current needs, we will be in touch with you about orientation. Please be advised that because of the number of applications we receive, we may not be able to place you as a volunteer at this time. We will keep your application on file for 60 days.

Step 1: To Be Completed by Applicant

Completely fill out, sign, and date all pages of the application. We have prepared an Application Checklist for your convenience; please include ALL of the following:

- ☐ **Application Pages 1 and 2**
- ☐ **The complete, signed reference form *in an envelope sealed by the reference, with their signature on the back flap***
- ☐ **Confidentiality Statement**
- ☐ **Parental Consent Form**
- ☐ **ALL medical documentation as indicated on page 1 of the Volunteer Health Assessment**
- ☐ **Page 2 of the Volunteer Health Assessment**
- ☐ **Employee Health and Wellness Consent for Minors**
- ➢ ***Please remember that we do not accept, consider or process incomplete applications.***

STEP 2: Mail Completed Application

We only accept applications by mail. Our mailing address can be found on page 2 of the application.

STEP 3: Orientation

An invitation to Volunteer Orientation will be sent to you if your application is complete and if your availability matches a current vacancy.

Part one of the TB screen tests are provided during orientation. Part two will be explained during the orientation.

STEP 4: Interview

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

Children's Hospital of Wisconsin

High School Volunteer Application

Please remember you must be 16 years or older to apply

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 the times you are **available** to volunteer: Example: If you are available from 2-4 pm on Monday and Wednesday, just enter it in the afternoon space for those days. Do not enter anything on the days you are not able to volunteer. **Minimum shifts are 2 hours.**

	MON	TUE	WED	THU	FRI
Morning					
Afternoon					
Evening					

Date available to start_____

Check your areas of interest: ☐**Clerical/Office Support** ☐**Patient Interaction** ☐**Gift Shop**

☐ **Service Desk: helping families and visitors at Welcome Centers, Family Resource Center etc.**

EDUCATION:

High School Name: _____ Graduation year: _____

Other Education: _____

_____

How did you hear about us?

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

_____

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

_____

_____

_____

_____

Rev/VS/ 07/12

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.

_____

_____

_____

EMERGENCY CONTACT (example: family member) :

Name: _____ Relationship: _____

Home phone: _(____) _____ Work phone: __(____)_____

Cell phone: _(____)_____

- ☐ I will volunteer at least 2 hours a week for a minimum of 6 months if I'm offered and accept a volunteer placement at Children's Hospital of Wisconsin; longer term volunteerism is welcome.
- ☐ I agree to have any medical tests and immunizations (example: TB , Measles-Mumps-Rubella ,Varicella/Chicken Pox, and Flu) required by Children's Hospital of Wisconsin.
- ☐ I understand that this application does not guarantee a volunteer placement at Children's Hospital of Wisconsin
- ☐ I certify that the statements made in this application are true and complete.

_____ _____

Signature Date

Please return the completed application packet including medical requirements and reference form to:

Children's Hospital of Wisconsin
Volunteer Services
999 North 92nd Street, C-115
P.O. Box 1997
Milwaukee, WI 53201

Immunization Records

The Wisconsin Department of Health and Human Services requires all hospital volunteers who may have patient contact to complete a health history and provide proof of **measles, mumps, rubella, and varicella 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.

1. **Please attach *official documentation* of having received 2 MMR (Measles, Mumps & Rubella) vaccines. Official documentation of immunizations/titer includes the following:**
   - Pediatrician, physician, or clinic documented immunizations.
   - Immunization records from a public health clinic.
   - Immunization records from a state database such as the WIR (Wisconsin Immunization Registry).
   - Military immunization records.
   - International immunization cards/Passport immunization records/WHO cards.
   - Records from employers or schools based on the above documents or actual test results, generally completed for the admission into a clinical or health care program or employment in a medical field.
   - ***Handwritten, family documentation is not acceptable.***

2. **Please provide *official documentation* regarding chickenpox (Varicella.) Evidence of immunity for HCP includes any of the following:**
   - Official documentation of vaccination with 2 doses of Varicella vaccine, or
   - Laboratory evidence of immunity or laboratory confirmation of disease (titer), or
   - Diagnosis or verification of a history of Varicella disease **by a health care provider,** or
   - Diagnosis or verification of a history of Herpes Zoster (shingles) **by a health care provider.** (A shingles vaccine does NOT provide immunity to chickenpox, and is not considered proof of immunity.)

Seasonal Flu Vaccinations

All Children's Hospital of Wisconsin volunteers and staff are required to receive the seasonal flu vaccine. You will receive notification when the Children's Hospital and Health System flu vaccine clinics are available each fall. The vaccine is available at no charge to volunteers. Official documentation of an influenza vaccine received elsewhere is required.

Volunteer Health Assessment

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 included 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 Practitioner, or Physician assistant

Children's Hospital of Wisconsin

Consent Form for Minors: Employee Health and Wellness Services

Tuberculosis (TB) screening is required for all volunteers. Before your child begins their volunteer experience at Children's Hospital, TB testing will be provided by Employee Health and Wellness. Volunteer Services will help make arrangements for these tests.

A two-step Tuberculosis Mantoux skin test will be given, with each test placed at least one week apart. It is necessary for your child to return to Employee Health and Wellness two to three days after the second test is placed, for "reading" the test site. Please be sure your child provides any documentation that is available regarding previous TB skin testing. A child who has had a prior positive tuberculin skin test or currently tests positive will be required to complete a written symptom survey. If test results or symptoms require it, Employee Health and Wellness will arrange for your child to have a chest x-ray and/or a Quantiferon blood test.

Children's requires the written consent of a parent or a legal guardian for a minor (anyone under 18 years of age) to participate in tuberculosis screening. The parent or legal guardian may ***not*** give telephone permission for the tuberculosis screening. A parent or legal guardian may accompany a minor to his/her appointment.

Children's also requires an annual Influenza vaccination for those volunteers at any Children's location between October 1 and March 31 of the following year. Your child may receive this vaccine without charge through Employee Health and Wellness, or must provide Volunteer Services with proof of vaccination received elsewhere prior to volunteering.

If you have any questions, please call the Employee Health and Wellness Nurse at (414) 266-8616.
Thank you for your cooperation.

NAME OF MINOR _____
(Please Print)

NAME OF PARENT / LEGAL GUARDIAN _____
(Please Print)

I give my consent for the minor named above to have a tuberculosis screening and/or influenza vaccination at Children's Hospital and Health System. This consent is valid and in effect for as long as this minor is volunteering at a Children's Hospital and Health System facility, or becomes legally authorized to give own consent.

_____ _____
(Parent/Guardian Signature) *(Date)*

Revised 7/12/2012

Children's Hospital of Wisconsin

Confidentiality Statement of Understanding (Volunteers)

I understand that information contained in medical or electronic records are the property of Children's Hospital of Wisconsin. Therefore, the patient has the right to expect that health records will be managed confidentially. It is the responsibility of Children's Hospital of Wisconsin 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 for the protection of the information.

2. Confidential documents may not be removed from Children's Hospital of Wisconsin 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 7/9/12

Children's
Hospital of Wisconsin

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. 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 WI. 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 (414) 266-2180.

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 Wisconsin. This consent is valid and in effect for as long as this minor volunteers at a Children's Hospital of Wisconsin, or becomes legally authorized to give own consent.

_____ _____
SIGNATURE **DATE**

Revised 7/9/2012

Volunteer Services Applicant Reference Form

Volunteer Applicant's Full Name _____

To the Volunteer – This form should be completed by an **Educational or Professional** reference and submitted with your volunteer application. (An educational or professional reference includes an employer, co-worker, teacher, coach, or school/religious official.)

To the Reference – this form cannot be completed for your child, friend, neighbor, or relative. All information you provide will be confidential. When you have completed this form, please place it in a sealed envelope, sign the back flap, and return it to the Applicant

How long have you know the applicant and in what capacity?

_____

_____

Please read the following statements about the applicant and indicate your choice based on experience

	Strongly Agree	Somewhat Agree	Do not Know	Somewhat Disagree	Strongly Disagree
Demonstrates initiative and dedication	❑	❑	❑	❑	❑
Ability to work independently	❑	❑	❑	❑	❑
Adapts well to changing circumstances	❑	❑	❑	❑	❑
Ability to follow instructions	❑	❑	❑	❑	❑
Possesses strong communication skills	❑	❑	❑	❑	❑
Able to fulfill commitments/responsibility	❑	❑	❑	❑	❑
Is open to new people and experiences	❑	❑	❑	❑	❑
Willingness to accept constructive criticism	❑	❑	❑	❑	❑

Do you feel the applicant is appropriate for interaction with hospitalized children and their families?

_____

_____

To what extent do you recommend the applicant for a volunteer position?

❑ No reservations ❑some reservations ❑significant reservations

Why?_____

_____

Reference information

Please Print Your Name_____ Phone _____

Profession/Title _____

Address _____

Signature _____ Date_____

THANK YOU for your feedback