SELF REGIONAL HEALTHCARE

# Student Volunteer Program

Requirements for
New Student Volunteer application
15 Years of age at time of application
Commit to 50 hours of service
Maintain "C" GPA

## #1 Application Deadline
## April 17, 2015

**Completed application form to include:**

- ◯ Demographic information
- ◯ Parent student policy agreement form
- ◯ Volunteer Code /Confidentially Pledge
- ◯ Parent Medical permission form
- ◯ 5 page Health History
- ◯ Counselor Reference form
- ◯ copy Current Immunization Record
- ◯ Current "Clear" Photo for Identification purpose

## #2
**Must attend**
**"one" of the two offered**
**parent/guardian & student meetings**
**Nisbit Building Auditorium**
**(gray block building across from the Emergency Room.. Edgefield & Academy )**
**6:00 pm**
**Tuesday May 12 or**
**Thursday May 14**

## #3
**All Students must attend**
**MANDATORY Student Volunteer training /orientation & TB screening**
**June 8th 9am - 3pm**
**Nisbit Center**
**(Gray building) across from Emergency Care Center**

*Thank you in advance for not asking for special consideration. SRH Team Members contributed their time and efforts to plan and organize the program.*

**The Student Volunteer Program will run from June 8th --July 30th.**
**Uniform to be worn at all times while on duty.**
**JV Shirt $25 purchased at Parent /Student Meeting**
**Student supplies Khaki pants and comfortable closed toe shoe (athletic)**
**ID badge will be issued at orientation & must be worn entire time in the facility.**
Must complete at least 50 hours to attend "Wrap-up Party" & receive Letter of Recommendation

**KEEP THIS FORM FOR INFORMATION -DATES**

SELF REGIONAL HEALTHCARE

# New Student Volunteer Application

STUDENT VOLUNTEERS MUST BE BETWEEN THE AGES OF 15-18 AT TIME OF APPLICATION

***General Information:*** ***Please Type or Print in all capital letters for LEGIBILITY***

Date:____/____/____ T-Shirt Size: (S ) (M) (LG) (XL) (2XL) ( ) cost $25.00

circle size

Name_____
(Last) (First) (Full Middle)

Home Address_____
Street City State Zip

Home Phone _____ Cell Phone _____

**E-mail**_____

Social Security #_____ Date of Birth ____/___/____ Age_____(required)

School Name _____current grade _____ GPA_____

Parent/ Legal Guardian _____

Home Phone_____ Cell Phone _____ Work Phone_____

Address ( if different from above) _____

**E-mail Address** _____

Emergency Contact (if different from above)

Name_____Relationship_____

Home Phone_____ Cell Phone _____ Work Phone_____

## COMPLETED APPLICATION DEADLINE

## Date Friday April 17, 2015

Self Regional Healthcare Volunteer Services
1325 Spring St
Greenwood SC 29646
phone 864-725-4878 or 725-4177

This program has a very large applicant pool and not all applicants can be accepted.

**NOTE! The entire packet must be completed for the student's consideration.**

# Student Volunteer Program
# Parent & Student Policy Agreement Form

I_____ have read the entire Self Regional Student Volunteer Program information.
(Please Print)

I have reviewed this information with my child _____.
(Please Print)

I understand the policy components and have asked the Volunteer Services Office to clarify any aspect of the program that I did not understand. I agree to abide by the policy set forth as it pertains to my child's participation in the Student Volunteer Program. I also understand that any act my child or myself commits that does not coincide with the standards/ requirements will result in the student not particapating in the program.

I understand that there is a required parent/ student session, May 12th (6PM) or May 14th (6PM) at the Nesbit Center (gray block building) located across the street from the Emergency Care Center and we agree to attend one of the two sessions offered.. If we are unable to attend; my child will not be able to participate in the program.

By returning this application, I am affirming that my child is available and will attend the June 8, 2015, 9am - 3pm training and orientation session and has committed to complete 50 hours of service for this program. This training will be held at the Nesbit Center (Gray block building across from the Emergency Care Center)

I understand that if my child should be unable to attend training on this date for any reason, that an alternate training date is **NOT OFFERED** and he/ she will be unable to participate in the 2015 Student Volunteer Program.

I have read the attached information and requirements and will encourage conformity to the rules of Self Regional Healthcare and the Student Junior Volunteer Program. I grant permission for my student to receive a TB skin test as part of the requirements for service.

Parent Signature _____ Date ____/____/____

Student Signature_____ Date ____/____/____

## *VOLUNTEER CODE*

According to hospital policies and procedures, volunteers must adhere to hospital policies and confidentiality codes just as employees are required to do. ***Please read carefully the following policies in the volunteer code and the confidentiality code and sign both to indicate your understanding and acceptance of the content of each.***

1. A volunteer is a part of the hospital organization, subject to all hospital rules, regulations, and proper authority.
2. A volunteer is subject to the code of ethics governing the professional staff of the hospital. It is important therefore to:

- Respect all information concerning the hospital and patients as confidential
- Follow instructions meticulously
- Be dignified, pleasant, and quietly efficient
- Remember that to outsiders you and your actions represent the hospital
- Never take advantage of your association with the hospital
- Use the greatest discretion in speaking with patients or visitors. Criticism of the hospital or staff should be taken up with the Director of Volunteer Services so that the situation can be properly investigated.
- Be dependable and to be on time. If you cannot come, please call the day before if possible so we can get a substitute.

SIGNATURE_____ DATE_____

## *CONFIDENTIALITY PLEDGE*

I understand, as a Volunteer of Self Regional Healthcare, I may come in contact with information that is considered confidential. Hospital information including patient related information such as patient conditions, problems, diagnosis, or medications and employee information such as employment status, hours of work, or wages is confidential.

I understand and agree as a volunteer, I will hold all Hospital information in confidence. I understand any violation of the confidentiality of medical information will result in the counseling process and may lead to dismissal.

SIGNATURE_____ DATE_____

Self Regional Healthcare
Employee Health Services
Phone (864) 725-4752
Fax (864) 725-4945
1325 Spring Street
Greenwood, SC 29646

*The Parent or Guardian must sign this form*



**Parental Permission**

**Medical Treatment**

**I give permission as parent or legal guardian of:**

_____

**(Student's Full Name – Please Print)**

**1) To be tested as deemed necessary for immunity to RUBELLA (German or 3 day measles) RUBEOLA (7 day or red measles), MUMPS and or VARICELLA (chicken pox) by the Self Regional Healthcare's Employee Health Nurse. I understand that I may contact the nurse at the above telephone number with any questions, and that I may accompany my child. Based upon the test results, I understand that there may be vaccinations and/or boosters recommended, and I will be provided vaccine information sheets and consent forms before the vaccinations are administered. (This is in the event we do not have a current immunization record).**

**2) To receive TB skin tests and/or chest x-ray from the Self Regional Healthcare Employee Health Nurse. I understand that this is a requirement to volunteer at our facility. I understand that if there is redness, swelling or hardness around the injection site prior to the time it is seen by Employee Health, I should contact the Self Regional Employee Health Office immediately at the above number.**

**3) To receive emergency medical treatment if he/she becomes ill or injured at work.**

**Signature** _____ **Date:** _____

**Relationship:** _____

**Address:** _____

_____

**Telephone number:** _____ _____ _____

**(Home) (Cell) (Work)**

Mandatory for participation in the Student Healthcare Connection Program

# EMPLOYEE HEALTH SERVICES
# HEALTH HISTORY FORM

#5

NAME_____ DATE_____

ADDRESS_____ MALE / FEMALE

CITY _____ STATE_____ ZIP_____

SSN_____ DATE OF BIRTH_____ AGE_____

PHONE (HOME) _____ (CELL) _____

EMERGENCY CONTACT_____ RELATION_____

ADDRESS (IF DIFFERENT FROM ABOVE)_____ PHONE_____-_____

PRIMARY PHYSICIAN_____

JOB POSITION _____ DEPT_____ MANAGER_____

| Have you had or do you currently have any of the following diseases? | YES | NO |
|---|---|---|
| Rubella (German Measles) | | |
| Rubeola (Red Measles) | | |
| Mumps | | |
| Polio | | |
| Varicella (Chicken Pox) | | |
| When was your last Tetanus Shot?<br>Year: | | |
| Have you ever had a Tdap vaccine (Tetanus, Diphtheria, Pertussis)?<br>Date: | | |
| Have you been vaccinated against Hepatitis B?<br>If yes, then list dates: #1 #2 #3 Physician Office/Health Dept | | |
| Have you ever had a POSITIVE TB skin test? If yes, then<br>list date of + test: Last CXR date: Results:<br>Did you take INH? Date: | | |
| Do you smoke now? If yes, then<br>how long: _____ # of years, _____# of packs a day | | |
| Have you quit smoking? If yes,<br>when (year)? | | |
| Do you drink alcohol? If yes, then<br># of drinks a day: type of alcohol: amount: | | |
| Do you exercise? If yes, then<br>times a week: type of exercise: how long (minutes): | | |
| Do you perform Self Breast Exams (female)? If yes, how frequently? | | |
| Do you perform Self Testicular Exams (male)? If yes, how frequently? | | |
| | | |

To the best of your knowledge do you have or have had any of the following medical problems?

| | YES | NO | | YES | NO |
|---|---|---|---|---|---|
| **Epilepsy** | | | **Diabetes** | | |
| **Cardiac Disease** | | | **Arthritis** | | |
| **Amputated foot, leg, hand or arm** | | | **Parkinson's Disease** | | |
| **Residual disability from Polio** | | | **Multiple sclerosis** | | |
| **Cerebral palsy** – Do you have a weakness or stiffness of arm, legs or other body parts that resulted from birth, injury or diseases? Any spasticity? | | | **Loss of sight** of one or both eyes or partial loss of uncorrected of more than 75% bilaterally | | |
| **Tuberculosis** | | | **Cerebral vascular accident** – Stroke or ruptured blood vessel in the head | | |
| **Silicosis** – Chronic cough, emphysema or other lung problems due to inhalation of dust | | | **Psychoneurotic disability** which involved treatment in a recognized medical or mental institution. | | |
| **Hemophilia** – Do you bleed easily and have a hard time stopping the bleeding? | | | **Chronic osteomyelitis** – Long term infection of bones or sores of the skin | | |
| **Ankylosis of joints** – Joints that are still and will not fully move. Frozen joints. | | | **Arteriosclerosis** – Poor circulation, cold extremities, pain in legs while walking | | |
| **Hyperinsulinism** – Excessive insulin the in the blood with low blood sugar and periods of weakness or fainting due to low blood sugar | | | **Thrombophlebitis** – Infection or inflammation of veins in legs – swelling or tenderness in calves of legs | | |
| **Varicose veins** | | | **Heavy metal poisoning** | | |
| **Ruptured disc** | | | **Hodgkin's disease** | | |
| **Brain damage** | | | **Deafness** | | |
| **Sickle-cell anemia** | | | **Cancer** | | |
| **Pulmonary disease** | | | **Degenerative disc disease** | | |
| **Spondylosis** | | | **Chondromalacia** | | |
| **Hepatitis** | | | **HIV** | | |
| **Other:** | | | | | |

**If you listed ARTHRITIS, please identify the parts of the body affected:**

_____

_____

_____

**A. For "yes" responses in the previous table, indicate the nature of injury or illness, date, and name of physician in Remarks.**

**Remarks**

_____

_____

_____

**B. Has any doctor ever restricted your activities?** ☐ YES ☐ NO

If so, please list the medical condition, what type of restrictions placed, whether these restrictions were temporary or permanent, and whether you are presently under these restrictions.

_____

_____

_____

_____

C. Have you ever been assessed any percentage of permanent disability to any part of your body for any reason whatsoever? **☐ YES** **☐ NO**

**If so, please explain:**

_____

_____

_____

**D. Are you presently under any medical treatment by a doctor, chiropractor, psychiatrist, psychologist or other health care provider?** ☐ YES ☐ NO

If so, please list the medical condition(s) being treated, the name of the doctor(s), field of specialty, and address and telephone number.
If applicable, please list the names and addresses of any hospitals where psychiatric or psychological treatment was provided and dates.

_____

_____

_____

_____

**E. Are you taking any medication(s)?** ☐ YES ☐ NO

If yes, please list the medication(s), the medical condition being treated, and the name, address and telephone number of the doctor who prescribed the medication. Include prescription, birth control pills, vitamins, herbal products, aspirin and other over-the-counter medications. Please name strength and frequency, if known.

_____

_____

_____

_____

_____

**F. Have you ever had surgery to any part of your body?** ☐ YES ☐ NO

If yes, please list the part(s) of the body operated on, the type of operation performed, the date of the operation, the name of the hospital, if any, where the operation was performed, and the name address and phone number of the doctor performing the surgery.

_____

_____

_____

**G. Have you ever received treatment for your back, neck, knees or lower extremities from a doctor, chiropractor, therapist or other health care provider?** ☐ YES ☐ NO

If yes, please list the name, address and phone number of all doctors, chiropractors, therapist or other health care provider who provided such treatment, the dates of the treatment and the diagnosis provided by the doctor, chiropractor, therapist, or other health care provider.

_____

_____

_____

**H. Have you ever had an injury that required you to miss time from work?** ☐ YES ☐ NO

If yes, please list the type of injury, the amount of time missed from work, whether the condition was fully resolved or if it left you with any impairment, and whether you returned to work.

_____

_____

_____

I. **Are you aware of any condition or injury that might impair or limit your ability to work for this company?** ☐ YES ☐ NO

If yes, please describe the condition or injury.

_____

_____

_____

_____

J. **Have you ever had a reaction, allergy and/or sensitivity to any drugs, foods? Chemicals or other?** ☐ YES ☐ NO

If yes, please list.

_____

_____

_____

K. **Have you ever been exposed to nitrous oxide, formaldehyde, glutaraldehyde, chemotoxic drugs, others?** ☐ YES ☐ NO

If yes, please explain.

_____

_____

L. **Will you be working with hazardous substances (nitrous oxide, formaldehyde, glutaraldehyde, chemotoxic drugs, others?** ☐ YES (Fit Testing Required) ☐ NO

If yes, please explain.

_____

**I HAVE READ AND FULLY UNDERSTAND THE ABOVE.**

**Employee/Applicant:**_____ **DATE:** _____

**Health Nurse Signature:** _____**DATE:** _____

## Student Volunteer Program Self Regional Healthcare 2015

## Counselor Reference Form …

The following student has expressed an interest in becoming a part of the summer program for Students interested in t Student Volunteer Program at Self Regional Healthcare. These students provide assistance and clerical support in vario departments of the facility. Although they are supervised, they are expected to be dependable, honest, and truly interested in t program.

High school students find out that community service isn't just the right thing to do, but is also an important component of college applications.Experiences in significant community service often demonstrate unusual promise for leadership. As college admissions have increased across the board, high school students are more pressured than ever to distinguish themselves from the competition. It is clear that passion and commitment to something bigger pla a key role in their decisions. Taking the lead to bring about change through Volunteering will help set a student apart from his or her peers.

- **Completed applications must be in the Volunteer Services Department by April 17 for consideration.**
- **All the required steps that are listed on the cover sheet of the application are mandatory for acceptance into to Self Regional Healthcare Student Volunteer Program.**

Your name has been given as their counselor. Please assist us in the selection process by evaluating this prospective applica Thank you in advance for your assistance and support of this program. Your ***prompt*** reply will be greatly appreciated as we ne this form in order to process the application. Please call 725-4878 or 725-4177, if you have questions.

**Reference for**: _____ Address _____

Grade _____School _____ Counselor _____ Date sent _____

**Please check the level of performance which reflects your opinion of this student.**

| Characteristic | Excellent | Good | Fair | Poor |
|---|---|---|---|---|
| 1. Communication: Gets along with others | _____ | _____ | _____ | |
| 2. Dependability: trustworthy, follows through | _____ | _____ | _____ | |
| 3. Attitude: positive, cheerful, willing to assist | _____ | | _____ | |
| 4. Appearance: neat, good personal hygiene | _____ | | _____ | |
| 5. Personal Values: honest & good character | _____ | | _____ | |
| 6. Leadership: takes initiative, respected by peers | _____ | | _____ | |
| 7. Potential: personal goals, high achiever | _____ | _____ | _____ | |

➢ I verify this student has at least an overall "C" grade point average. YES _____ NO _____

➢ Although this student's overall grade point average is below this level, I believe that he/she makes a sincere and diligent effort and would benefit significantly from the program without being a behavior problem.

➢ YES _____ NO _____ Comment: _____

Counselor's signature _____ Phone _____ Date _____

Counselor's email _____

**Please fax to Volunteer Services 725-6041 or mail to SRH, 1325 Spring Street, Greenwood SC 29646**