2024 STUDENT VOLUNTEER APPLICATION

DEADLINE FOR APPLICATION
TUESDAY, APRIL 30, 2024
DROP OFF APPLICATION AT
SHR VOLUNTEER OFFICE
KEEP THIS COVER SHEET PAGE FOR INFORMATION "READ CAREFULLY"
MANDATORY REQUIREMENTS

Students must be at least 16 years of age at the time of application.
Commit to completing 72 hours of service during the summer. Have at least a "C" average.
Return the completed application packet before the April 30, 2024 deadline - in order to be considered for the program. Thank you in advance for "not asking for special consideration."
Self Regional Team members contribute their time and efforts to plan and organize the health screening and orientation. The dates listed are the only times provided for students to come. Students must make arrangements in advance to comply with the dates set for requirements.

APPLICATION PROCESS

#1 Application Packet must contain each item listed below to be considered for the program

- Completed application packet includes:
- Demographic information
- Parent student policy agreement
- Volunteer code / Confidentiality Pledge
- Parental Consent Form
- 4 page health history form
- Counselor Reference Form
- Copy of current Immunization record
- Current "clear" photo identification purposes, Driver's License or School ID is acceptable

DO NOT FAX (INFORMATION IS NOT CLEAR

MANDATORY MEETING

2 If application is accepted!

Must attend ONE of the two offered parent/ guardian & student meetings.

Location for meeting:

Self Service Center Main Street
(4 story glass building between McDonald's and Piggly Wiggly)

5:00 PM
Tuesday, May 7, 2024
or
Thursday, May 9, 2024

REQUIRED DATES AND EVENTS

#3 All students that have been accepted and completed the above requirements Must schedule Health Screening by calling 725-4752 between May 13 - May 24

Health Screening between 6:30am - 1:30 pm
** Mention - Student Volunteer Summer Program when calling **

Must attend MANDATORY STUDENT VOLUNTEER ORIENTATION
MONDAY, JUNE 3, 2024 AT 9:00 AM

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.

2024 Student Volunteer Apllication

STUDENT VOLUNTEERS MUST BE BETWEEN THE AGES OF 16-18 AT TIME OF APPLICATION

General Information: *Please type or print in all capital letters for LEGIBILITY*

circle size

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

Name____
(Last) (First) (Full Middle)

Home Address____
Street City State Zip

Student Home Phone ____________________ Student 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 April 30, 2024

Self Regional Healthcare Volunteer Services

1325 Spring St Greenwood SC 29646 phone (864) 725-4177

SELF REGIONAL HEALTHCARE

Attendance Requirements
Student Volunteer Program
Parent & Teacher Policy Agreement Form

I ______________________ have read the entire Self Regional Student Volunteer Program information.
(PARENT NAME PLEASE PRINT)

I have reviewed this information with my child ______________________________________
(STUDENT NAME PLEASE PRINT)

I understand the policy components and have asked the Volunteer Services Office to clarify any aspects of the program that I did not understand. I agree 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 results in the student not participation in the program.

I understand that there is a required parent/student session, that will be held in May at Self Service Center on Main Street next to McDonald's and we agree to attend one of the two sessions offered listed below. If we are unable to attend my child will not be able to participate in the program.

TUESDAY, MAY 7, 2024 OR THURSDAY, MAY 9, 2024

By returning this application, I am affirming that my child is available and will attend the Monday June 3, 2024 training and orientation session 9:00 am - 1:00 pm and has committed to complete 72 hours of service for this program.

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

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

Parent Signature________________________________ Date ____________________

Student Signature_______________________________ Date ____________________

SELF REGIONAL HEALTHCARE

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.

Parent Signature____ **DATE**____________________

Student 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 any violation of the Confidentiality Policy and Self Regional Standards will lead to dismissal from the Student Volunteer Program.

Parent Signature____ **DATE**____________________

Student Signature____ **DATE**____________________

Parental Consent Form

Dear Parent or Guardian:

In order for your child to apply for a volunteer position with The Self Regional Healthcare Volunteer Program, we need your consent and involvement in helping your child have a productive experience. Please carefully read and sign this parental consent form if you would like us to continue our process of considering your child as a possible volunteer. If you have any questions or would like further information, please call the Department of Volunteer Services at 864-725-4177.

Name of prospective volunteer: ____

- I understand that my child (named above) wishes to be considered for a volunteer placement and I hereby give my permission for him/her to serve in that capacity, if accepted by Self Regional Healthcare Department of Volunteer Services.
- I understand that my child must be at least 16 years of age to volunteer.
- I understand that my child will not receive monetary compensation for the services contributed.
- I understand that my child will receive an employee health exam free of charge.
- I understand that my child is required to receive a **tuberculosis screening** free of charge.
- **If an x-ray is required a parent/guardian must accompany him/her.**
- I understand that my child is required to receive an **influenza vaccination,** free of charge, during flu season.
- I understand that my child will be provided with the orientation and training necessary for the safe and responsible performance of the duties assigned. He/she will be expected to meet all the requirements of the position, including regular attendance and adherence to the hospital policies and procedures of the department being served.
- I understand that my child will be provided emergency medical care if injured while he/she is on duty as a volunteer.

Parent/Guardian's Name (please print): ______________________________________

Signature: ____

Nature of relationship to volunteer: _________________________

Date: ___________________

EMPLOYEE HEALTH SERVICES
HEALTH HISTORY FORM

NAME:	EMP ID	DOB:	MALE / FEMALE
PHONE: HOME ( ) -	PHONE: CELL ( ) -	EMERGENCY (NAME):	PHONE: ( ) -
ADDRESS:	CITY:	STATE:	ZIP CODE:
DEPARTMENT:	POSITION:	SHIFT:	MANAGER:
PRIMARY PHYSICIAN:	DATE OF HIRE:	TODAY'S DATE:	WT: # HT: ft in

A. OCCUPATIONAL HISTORY		YES	NO	EXPLANATION
1.	Have you ever been exposed to hazardous substances in previous jobs?			
2.	Have you been told by a healthcare professional that you are allergic to any latex (rubber) products? *Documentation Required*			
3.	Have you had contact with any substances/items that caused a reaction? (balloons, condoms, band-aids, elastic, etc.)			
4.	Do you have allergies to foods or certain environments? (avocados, bananas, dust, pollen, etc.)			
5.	Have you had any type of an allergic reaction during a medical or dental procedure? (rash, swelling, shortness of breath, etc.)			
6.	Have you ever worked with sheet metal or welding/soldering, or had an accident where metal fragments became or may have become embedded in your eyes or other parts of your body?			
7.	Have you ever been injured at work?			

B. IMMUNIZATION HISTORY ***** PLEASE BRING YOUR IMMUNIZATION RECORD *****

- ☐ MMR (measles, mumps, rubella) ☐ Varicella (chicken pox) ☐ Tetanus
- ☐ Tdap (tetanus, diphtheria, pertussis) ☐ Hepatitis B ☐ Meningitis ☐ Covid

C. MEDICAL HISTORY (Please check all that apply)							
☐	DIZZINESS/FAINTING	☐	VOMITING	☐	HEADACHES – FREQUENT	☐	DIABETES
☐	EAR INFECTIONS	☐	JAUNDICE/HEPATITIS	☐	MIGRAINES	☐	WEIGHT LOSS/ RECENT (Unknown Reason)
☐	HEARING LOSS	☐	DIVERTICULITIS	☐	NECK PAIN - CHRONIC, RECURRENT, ACUTE	☐	SURGICALLY/ ACCIDENTALLY IMPLANTED METAL OBJECTS/DEVICES:
☐	RINGING IN EARS	☐	CROHN'S/COLITIS	☐	TMJ		
☐	EYE INFECTIONS	☐	DIARRHEA	☐	OSTEOPOROSIS (BRITTLE BONES, FRACTURES)		
☐	FAILING VISION	☐	IRRITABLE BOWEL SYNDROME	☐	SHOULDER PROBLEMS	☐	SURGERY TO ANY BODY PART: (NAME BODY PART, DATE, PHYSICIAN)
☐	GLASSES/CONTACTS	☐	HERNIA (GROIN, HIATAL)	☐	WRIST PROBLEMS		
☐	COLOR BLINDNESS	☐	CHEST PAIN	☐	SWOLLEN ANKLES		
☐	HAY FEVER/ALLERGY	☐	CORONARY ARTERY DISEASE	☐	VARICOSE VEINS		
☐	NOSE BLEEDS	☐	HEART MURMUR	☐	PHLEBITIS		
☐	SINUS TROUBLE	☐	HIGH BLOOD PRESSURE	☐	KIDNEY STONES		
☐	ASTHMA/WHEEZING	☐	LOW BLOOD PRESSURE	☐	CONVULSIONS/ SEIZURES	☐	RECEIVED TREATMENTS TO YOUR BACK, NECK, KNEES, OR LOWER EXTREMETIES: (NAME BODY PART, DATE, PHYSICIAN)
☐	BRONCHITIS	☐	HIGH CHOLESTEROL	☐	NUMBNESS/TINGLING SENSATION		
☐	CHRONIC COUGH	☐	IRREGULAR HEART BEAT	☐	TREMOR/HANDS SHAKING		
☐	PNEUMONIA	☐	STROKE	☐	DEPRESSION		
☐	SORE THROAT	☐	ANEMIA/BRUISE EASILY	☐	NERVOUSNESS		
☐	THYROID DISEASE	☐	ARTHRITIS	☐	DRUG/ALCOHOL ABUSE		
☐	DIFFICULTY SWALLOWING	☐	BACK PAIN – CHRONIC, RECURRENT, ACUTE	☐	PSORIASIS/ECZEMA	☐	HAVE YOU HAD AN INJURY THAT REQUIRED YOU TO MISS TIME FROM WORK: NAME TYPE, DATE, PHYSICIAN)
☐	ABDOMINAL PAIN – CHRONIC	☐	CARPAL TUNNEL SYNDROME	☐	RASHES/HIVES		
☐	GALLBLADDER TROUBLE	☐	ELBOW PROBLEMS (TENDONITIS)	☐	CANCER		
☐	INDIGESTION OR HEARTBURN	☐	FOOT/ANKLE PROBLEMS	☐	CHRONIC FATIGUE		
☐	LOSS OF APPETITE	☐	GOUT	☐	FIBROMYALGIA		
☐	UNEXPLAINED WEIGHT LOSS	☐	KNEE PROBLEMS	☐	MYOFASCIAL PAIN SYNDROME		
☐	PEPTIC ULCERS	☐	LEG PAIN/ WALKING	☐	RSD		
☐	PERSISTENT NAUSEA	☐	MUSCLE DISEASE	☐	LUPUS		

1. **Briefly explain any items checked above (Section C):**

____

____

____

2. **List any medications you are taking and include over-the-counter medications or supplements:**

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

3. **List and describe any medication, food, chemical, and/or environmental allergies:**

____

____

4. **Have you or your family ever had tuberculosis?** ☐Yes ☐No
If yes, please explain: ____

____

5. **Has any doctor ever restricted your activities?** ☐Yes ☐No **Explanation:** ______________

____

____

6. **Have you ever been assessed for partial or permanent disability to any part of your body for any reason?** ☐Yes ☐No **Explanation:** ______________________

____

____

7. **Are you currently under the care of or receiving ongoing medical treatment from a doctor, chiropractor, psychiatrist, psychologist or other health care provider?** ☐Yes ☐No
Explanation: ____

____

____

8. **Do you have any conditions which prevent you from performing the essential functions of this job or require a request for accommodations?** ☐Yes ☐No
If yes, please describe: ____

____

____

****

The above statements are true to the best of my knowledge. I understand that any misstatement of fact may be grounds for release. I give permission to contact agencies and /or individuals who are, or have been, involved in my care and/or treatment. I also give permission for lab testing to be done if applicable.

Date: ______________ **Signature of Applicant:** ______________________________

Date: ______________ **Reviewed by Employee Health:** __________________________

** OFFICE STAFF ONLY **

EMPLOYEE HEALTH NURSE (OCCUPATIONAL SAFETY EDUCATION):

- ☐ **Vaccines (live virus):**
  - **Patients in high risk areas such as Cancer Center, NICU, L&D, ECC, etc.)**
  - **Vaccine available for occupational risk (meningococcal vaccine for microbiology)**
- ☐ **Hazards:**
  - **PPE, Right-To-Know**
  - **Chemicals (EVS, Lab, etc.)**
  - **Infections (Worker/Patients)**
  - **Drugs (Pharmacy, Cancer Center nurses)**

MEDICAL CLEARANCE NEEDED PRIOR TO ORIENTATION:

☐ **Referral to ANP/PMD** ☐ **Sent for POPE** **Other Clearance needed:** ____________________

EH Nurse Comments: ____

____

____

____

☐ **See ancillary nurses notes for additional documentation**

STUDENT VOLUNTEER PROGRAM 2023 SELF REGIONAL HEALTHCARE

COUNSEL REFERENCE FORM

The following student has expressed an interest in becoming a part of the summer program for students interested in the Student Volunteer Program at Self Regional Healthcare. These students provide assistance and clerical support in various departments of the facility. Although they are supervised, they are expected to be dependable, honest and truly interested in the 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 demonstrates unusual promise of leadership. High school students are more pressured than ever to distinguish themselves from the competition. It is clear that passion and commitment to something bigger play 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 30, 2024 for consideration**

***** All the required steps that are listed on the cover sheet of the application are mandatory for acceptance into the Self Regional Healthcare student Volunteer Program. No exceptions**

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

This is the only form that may be FAXED

Please fax to Volunteer Services 725-4217 or email to anthony.cappellini@selfregional.org

Immunization Records
Needed Documentation For Student Volunteers:

Please provide copies of the following

- Hepatitis B Vaccination Series
- TDap Vaccine (Given within the last 10 years - Mandatory Vaccine)
- Two Varivax “Chicken Pox” Vaccines
- Two MMR Vaccines
- Flu Vaccine for the current Flu season - if during flu season

***** If you DO NOT have these we CAN NOT move forward!!**

Self Regional Healthcare
Student Volunteer Work Assignment

Students assignments will be scheduled on a FIRST COME - FIRST SERVE BASIS
The date that the completed application and this form are received will be a deciding factor in making this decision.

Students Name: ____

- **WORK ASSIGNMENTS WILL BE MADE AT RANDOM AND THAT WILL BE YOUR SCHEDULE FOR THE DURATION OF THE PROGRAM - SCHEDULING WILL BE DONE ON THE FIRST COME FIRST SERVE BASIS. The date that the "COMPLETED APPLICATION" IS RECEIVED WILL BE THE DECIDING FACTOR IN MAKING DECISIONS.**
- **Each student is required to work four 4 hour shifts (9AM-1PM or 1PM - 5PM) for a total of 72 hours within 6 weeks of Service from June 3 - until July 19, 2024. We normally do not schedule students on Friday.**
- **Students need to arrive 15 minutes prior to their shift to allow time to clock in and report to their assigned area of service.**

SCHEDULE PREFERENCE: We will try to honor your first request. However, with the large number of students it is sometimes impossible.

*Please indicate your **SCHEDULE PREFERENCE:***
Place a #1 in the box next to your first choice. The indicate a second choice (in the event we are unable to accommodate your first one) by placing a #2 in the box next to your second choice.

Four Mornings	*9:00 AM - 1:00 PM*	☐
Four afternoon shifts	*1:00 PM - 5:00 PM*	☐

If you carpool, indicate the name of **ONLY ONE** other person you plan to ride with. Attempting to schedule more than two youth together is not feasible and these request will not be honored.
Also make sure your scheduling request coincide.
Name of student you will be carpooling with: ____________________________

TWO STUDENTS ARE NEVER PLACED IN THE SAME AREA OF SERVICE AT THE SAME TIME.
STUDENTS ARE NOT ASSIGNED TO AREA WHERE FAMILY MEMBERS WORK.

What do volunteers do?

All students will have completed HIPPA training, TB Test and orientation.

1. Escort patients to appointments.
2. Greet, direct and provide way-finding for patients and visitors.
3. Maintain cleanliness of patient and public waiting areas.
4. Escort/walk patients and visitors to clinic locations.
5. Assist discharge patients to main lobby / entrance.
6. Deliver flowers, mail, books and magazines to patients.
7. Make deliveries from departments throughout medical center.
8. File paperwork/charts, enter data and answer telephones.
9. Assist nurses and PCTs, with non-direct patient care duties.
10. Stock blanket warmers and nutrition supplies on nursing units.
11. Wipe down wheelchairs, stretchers and equipment as needed..
12. Act as a liaison between patient families and medical center staff.
13. Gift Shop and Hope Chest in Cancer Center
14. Nursing units
15. Patient information desk