



Flagler Health+ AUXILIARY

400 Health Park Blvd., St. Augustine, FL 32086

Date: _____

(904) 819-4411

PLEASE PRINT

APPLICATION FOR JUNIOR VOLUNTEER 2023 PROGRAM

Please read carefully, print clearly and answer all questions. Submit application to
Volunteer Services, Suite 1010, Flagler Hospital, 400 Health Park Blvd., St Augustine 32086

Or

Rita.Hubbs@FlaglerHealth.org

PERSONAL/CONTACT INFORMATION:

Name: _____
Last First MI

Street Address: _____ Apt. # _____

City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-Mail: _____

Sex: _____ Male _____ Female Birthdate: _____ - _____ - _____
M D Y

IN CASE OF EMERGENCY, NOTIFY:

Parent/Legal Guardian: _____ Relationship: _____

Street Address (if different from above): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell Phone: _____

Email Address: _____

Physician's Name: _____ Phone: _____

SCHEDULE PREFERENCES:

Work Shift: Mornings Afternoons Flexible

Work Day: Tuesday Wednesday

 Thursday Friday Flexible

Why do you want to volunteer at Flagler Hospital?

EDUCATION INFORMATION

School Attending: _____ Grade Level Fall, 2023 _____

Guidance Counselor: _____ Phone: _____

SKILLS, ACTIVITIES AND WORK EXPERIENCE:

Special Skills and Talents:

School Activities and Awards: _____

Community Affiliations: _____

Volunteer Experience: _____

Languages: _____

Are you interested in the Medical Field? () Yes () No

Area interested: _____ Physician
_____ Nursing
_____ Pharmacist
_____ Surgeon
_____ Physical Therapist
_____ Radiologist
_____ Other (please explain)

SHIRT SIZE

Ladies **S** **M** **L** **XL**

Mens **S** **M** **L** **XL**

MEDICAL HISTORY and AUTHORIZATION

DATE: _____

As a potential Flagler Hospital Junior Volunteer you will be required to complete a 2-step Tuberculosis (TB) skin test prior to being placed into a volunteer position. If you have a positive reaction to a TB skin test, you will be screened by our Employee Health nurse and given instructions if a follow up is necessary. The hospital will provide the TB skin test **free of charge at Flagler Hospital** during regularly scheduled clinic hours.

VOLUNTEER NAME: _____ **AGE:** _____

ALL VOLUNTEERS MUST CONSENT TO HAVING COVID VACCINATIONS.

MEDICAL HISTORY

List Any Restrictions of Applicant: _____

Last Tetanus/Toxoid Booster: _____

Last Flu Shot _____

Last COVID Vaccination _____

Allergies to Drugs/Food: _____

Pertinent Medical History and any Special Medications Taken: _____

TO PARENT:

If your child has epilepsy, diabetes, allergies, heart condition, etc., and/or is taking special medication for any condition, it is important that you advise us so that in the event of an emergency resulting from his/her illness, medical personnel can provide proper treatment. This information will at all times remain confidential, except where it affects his/her ability to receive medical attention.

List any Physical Limitations of Child: _____

AUTHORIZATION

I, we, the undersigned, parent(s)/legal guardian of _____, a minor, in any emergency situation, do hereby authorize Employee Health Nurse or Designee as agents for the undersigned to consent to any Flagler Hospital: (1) pre-volunteer testing required, 2 step Tuberculosis (TB) skin test (2) x-ray examination; (3) anesthetic; (4) medical or surgical diagnosis or treatment and hospital care which is deemed advisably by, and is to be rendered under the general or special supervision of any physician licensed under the provisions of the Medicine Practice Act on the medical staff of the above named hospital, when such diagnosis or treatment is rendered at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis or hospital care being required and is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment of hospital care which the aforementioned physicians, in the exercise of his/her best judgment, may deem advisable in any emergency situation.

It is understood that the effort shall be made to contact the undersigned prior to rendering treatment to the patient, and that any of the above treatment will not be withheld if the undersigned cannot be reached.

SIGNATURE OF PARENT/LEGAL GUARDIAN: _____

Relationship to Student: _____

STUDENT VOLUNTEER CONTRACT

IF ACCEPTED INTO THE FLAGLER HOSPITAL JUNIOR VOLUNTEER PROGRAM, I AGREE TO:

- **Commit to participate the entire Four (4) Week Period: June 19 until July 21, 2023.**
- Attend **MANDATORY** Orientation and in-service training scheduled for **Friday, June 16, 2023.**
- I understand and am able to fulfill the requirement to work a minimum of 4 hours a week.
- I will hold all information as confidential concerning patients, families, staff members, physicians and volunteers.
- Become familiar with Flagler Hospital policies and procedures and uphold the Code of Conduct.
- Be punctual to my assigned area.
- Honor my commitment to a specific job assignment.
- Donate my services without contemplation of compensation or future employment.
- I will make my service professional in all ways. I will conduct myself with dignity, courtesy and have consideration for others.
- Purchase the appropriate volunteer uniform and maintain a well-groomed appearance.
- Carry out assignments in a professional manner and seek Auxiliary assistance when necessary.
- Discuss any problems, criticism or suggestions with the Director of Volunteer Services.
- Adhere to the Flagler Hospital Auxiliary + sign-in procedure.
- Participate in the Flagler Health+ mandatory Covid prevention program.
- I understand that the following may result in immediate dismissal: Breach of confidentiality; Lack of honesty; Failure to complete work; Personal attacks; not showing up to work as scheduled.
- I will not make or receive personal phone calls (land line or cellular) while on duty unless it is for emergency purposes. This includes text messages.
- I understand that only patients are to be seated and/or transported in the hospital wheelchairs.
- I understand that I must be in compliance with the dress code as presented in pre-program interviews.

Student Signature _____

Date _____

PARENT/GUARDIAN AGREEMENT

- **My child must commit to participate for the entire 4 week program, from June 19 until July 21, 2023.**
- My child must attend **MANDATORY** orientation and in-service training scheduled for **Friday, June 16, 2023, 9:30 – 11:30 a.m.**
- My child must work in the assigned area. Assignments cannot be changed without the express permission of the Volunteer Services Department.
- I understand that **Volunteer Services Department** reserves the right to terminate my child’s status as a result of (a) failure to comply with Flagler Hospital policies; (b) absences without prior notification; (c) unsatisfactory attitude, work or appearance, or (d) any other circumstances which, in the judgment of the department director, would make continued services as a volunteer contrary to the best interests of Flagler Hospital and its patients.
- I give my consent for my son/daughter to submit this application to join the Flagler Hospital Junior Volunteer Program.
- I give consent for Flagler Hospital to administer to my child a 2 step Tuberculosis (TB) skin test.

SIGNATURES:

_____ **Parent/Guardian Signature**

_____ **Student Applicant Signature**

STUDENT’S NAME: _____

TEACHER RECOMMENDATION:

I recommend _____ to serve as a Flagler Hospital Junior Volunteer.

Comments: His/Her grade point average is a 3.0. or higher:

Teachers Signature: _____

Date: _____

School: _____

Phone: _____

ADULT RECOMMENDATION:

I recommend _____ to serve as a Flagler Hospital Junior Volunteer.

Comments: _____

Reference Signature: _____

Date: _____

Reference Phone #: _____