Gulfside Hospice
Lic. 1989

T E E N
VOLUNTEER APPLICATION

I am interested in becoming a TEEN VOLUNTEER …

NAME: _____
(last) (first) (middle)

ADDRESS: _____
(street) (city) (state) (zip code)

TELEPHONE NUMBER: Home _____ **Cell**_____

DATE OF BIRTH: _____ **E-MAIL**_____

SCHOOL:_____ **GRADE**_____

Special Skills/Interests:_____
_____

Are you available to work: Monday ☐ Tuesday ☐ Wednesday ☐
Thursday ☐ Friday ☐ Saturday ☐ Sunday ☐

Please explain any disability that would interfere/ with your performing as a volunteer:
_____

Please check the space next to the Volunteer Program(s) in which you have an interest:

☐ Thrift Shoppe ☐ Office ☐ Assisted Living
☐ Nursing Home ☐ In Patient Care Centers/Facilities ☐ OTHER

In case of an emergency, please notify:
Name:_____ Relationship:_____
Address:_____ Phone:_____

References: Name:_____ Relationship:_____
Address:_____
Phone:_____

References: Name:_____ Relationship:_____
Address:_____
Phone:_____

References: Name:_____ Relationship:_____
Address:_____
Phone:_____

DOCUMENTATION REQUIRED: Copy of Student ID card and Driver's License and Automobile Insurance indicating the name of responsible party, I understand that I must be 15 years old (with two references).

I authorize investigation of statements contained in this application. I understand that the misrepresentation or omission may be cause for dismissal. Further, I understand that my Volunteer Work is not for any definite period of time and may be terminated at any time without previous notice.

_____ _____
Applicant's Signature - Date **Signature of Parent or Guardian – Date**

Parent/Guardian Consent for Hospice Teen Volunteers

This consent form is provided to the parents/guardians of teen volunteers under the age of 18. Because you play an important role in your child's experience as a hospice volunteer this form is intended to inform you of policies and procedures of the Gulfside Hospice. We ask that you read this with your child and sign the statements below.

- Universal Precautions used by all medical personnel when working with patients, are taught to your child during volunteer training. You are asked to indicate below your decision in regard to your child being placed with a patient who has a known communicable disease.
- Per HIPPA guidelines all patient information is to be kept confidential. Your child has signed a confidentiality statement. We realize that your child will benefit from sharing volunteer experiences with you. For this reason, we ask that you sign the Parent/Guardian Statement of Confidentiality below.
- Your child is required to complete and return a Volunteer Report form after each patient/family visit. This documentation becomes part of the medical records which Hospice relies on for the patient's plan of care and for government funding.

Consent

I,_____, parent/guardian of _____, do hereby consent for my teen to participate as a Hospice volunteer.

Patients with Known Communicable Diseases

Please check below to indicate that you grant or deny permission to your child to be assigned to a patient with a known communicable disease.

_____ I grant permission

_____ I do **not** grant permission

Parent/Guardian Statement of Confidentiality

I agree to keep confidential any information shared with me by my child who has volunteered for Gulfside Regional Hospice.

_____ _____ _____

Parent/Guardian Signature Print Name Date

Model Release

I hereby give Gulfside Hospice and Pasco Palliative Care, or its agents, the absolute right and permission to copyright and /or publish, or use video, photographic portraits or pictures of me, or statements made by me, made through any media at its studios or elsewhere, for art, advertising, trade or any other lawful purpose whatsoever.
I hereby waive any right that I may have to inspect and/or approve the finished product or the advertising copy that may be used in connection therewith, or the use to which it may be applied. I hereby release, discharge, and agree to save Gulfside Hospice and Pasco Palliative Care, and its agents from any liability or payment for use of my image or statements.

Model Name _____

Address _____

Phone _____

_____ _____
ADDRESS PHONE

Signature _____ Date _____

PARENT/GUARDIAN SIGNATURE (if a minor)

_____ Date _____

Witness _____ Date _____

GULFSIDE HOSPICE & PASCO PALLIATIVE CARE

Gulfside Hospice

NAME & TITLE:_____SS # _____

INFORMED CONSENT FOR TUBERCULOSIS TESTING

DEFINITION: Tuberculosis (TB) is an infectious disease, which usually affects the lungs but can affect other parts of the body as well. The usual signs are chronic cough, fatigue, night sweats, unexplained weight loss or fever, loss of appetite or coughing up blood.

PURPOSE: The purpose of a tuberculin skin test is to tell whether you have been exposed to the germs (bacteria) that cause TB.

PROCEDURE: A small amount of harmless tuberculin protein is injected into the surface layer of the skin, usually on the forearm. If the test is positive, it means you have been exposed to TB and you now have the germs in your body that cause TB. It may not mean that you have TB or that you can give it to other people. A chest x-ray will need to be done if the test results are positive.

INSTRUCTIONS: Do no be alarmed if you experience redness, warmth or bruising at the site of the injection. Do not cover the site with a band-aid, apply lotion of scrub the area. It is okay to use water on the site.

I do consent to be tested for TB with the results read in 48 to 72 hours

Signature_____ Date_____

Parent/Guardian Consent_____ _____
Signature Relationship

Manufacturer_____ Lot #_____ Exp. Date_____

Date Given_____ Site_____ Given by_____

Date Read_____ Results_____ Read by_____