



2008 Summer Teen Volunteer Program
First-time Teen Volunteer
Checklist

THANK YOU FOR YOUR INTEREST IN VOLUNTEERING AT UNIVERSITY HOSPITAL THIS SUMMER. VOLUNTEERING IS AN EXCITING WAY TO SPEND SOME OF YOUR SUMMER TIME, TO LEARN MORE ABOUT YOURSELF AND CONSIDER YOUR EDUCATION AND CAREER CHOICES.

PLEASE READ ALL THE APPLICATION MATERIALS AND FORMS, REVIEW THEM WITH YOUR PARENTS/GUARDIAN, COMPLETE EACH AND SUBMIT THEM BY MAIL OR IN PERSON BY 4 P.M. ON FRIDAY, MAY 30, AT THE ADDRESS BELOW. ALL ITEMS MUST BE SUBMITTED TOGETHER AND **NO EXTENSION CAN BE MADE**.

HERE ARE SOME PROGRAM DETAILS FOR YOUR CONSIDERATION:

- ◆ YOU MUST BE 14 YEARS OLD BY JUNE 1, 2008 TO PARTICIPATE IN THE PROGRAM
- ◆ THERE IS A MANDATORY ORIENTATION ON **MONDAY, JUNE 30**. IT WILL BEGIN AT **9AM SHARP** AND WILL END AROUND 2PM.
- ◆ ACCEPTANCE IS BASED ON SEVERAL FACTORS: SUITABILITY, SCHEDULING AND AVAILABLE OPENINGS
- ◆ YOU WILL BE EXPECTED TO DEVOTE A MINIMUM OF 50 HOURS OVER THE SUMMER, ON A REGULAR WEEKLY SCHEDULE. PLEASE CONSIDER YOUR SUMMER PLANS TO BE SURE YOU CAN MAKE THIS COMMITMENT
- ◆ ASSIGNMENTS AND SCHEDULES, INCLUDING VACATIONS AND ABSENCES, WILL BE DISCUSSED DURING YOUR INTERVIEW.
- ◆ YOU WILL HEAR FROM US BY JUNE 11 TO DISCUSS YOUR APPLICATION.

Check off each of the following as you complete them.

- _____ The application, completed neatly and legibly by the applicant
- _____ The Consent Form signed by a parent/guardian
- _____ Valid working papers (we will copy and return working papers, if requested)
- _____ Report of Medical History Form
- _____ Documentation of two (2) MMR (measles, mumps, rubella) vaccines
- _____ Recommendations from two adults (not parents/guardians) who know you well. One must be a teacher, guidance counselor or other school personnel. Ask each to seal the completed form in an envelope and sign across the seal.

Applicant Name (print) _____ Date _____

Signature: _____

Volunteer Services, Room 1401
University Hospital
750 E. Adams Street
Syracuse, NY 13210
(315) 464-5180



Teen Volunteer Application

Print Name:	First	Last		
Home Address:	Street	City	State	Zip
DOB:		Male/Female:		
Home Phone:	()	E-Mail Address:		
High School:				
Grade in Fall:				

Emergency Contact:	
Name:	Relationship:
Address:	Daytime Phone:

1. Why do you want to volunteer? What are your expectations (please be specific)?

2. List your school and community activities:

3. Please describe yourself:

4. Please give us 2 examples to demonstrate that you are dependable:

5. What are your other plans for this summer, including vacations and summer camps?

6. What are your career interests?

7. Do you have any special skills you would like to use while you volunteer? i.e. Computer skills, clerical skills, foreign language skills, etc.

8. Volunteer schedules are at least 4 hours a day, one day a week. You can do more than one day per week. Which days/times do you prefer? (weekdays only)

I UNDERSTAND THAT BY AGREEING TO PARTICIPATE IN THE 2008 TEEN VOLUNTEER PROGRAM I AM EXPECTED TO CONTRIBUTE AT LEAST 50 TOTAL HOURS ON A REGULAR WEEKLY SCHEDULE FOR THE DURATION OF THE PROGRAM (JUNE 30 – AUGUST 29, 2008).

I AGREE TO TAKE ADVANTAGE OF THIS OPPORTUNITY BY BEING PUNCTUAL AND RELIABLE. I UNDERSTAND I WILL LEARN MORE IF I DEMONSTRATE I AM INTERESTED BY SPEAKING UP, ASKING QUESTIONS, AND OFFERING TO HELP.

I WILL ATTEND THE ORIENTATION ON JUNE 30 AND WILL PAY ATTENTION TO THE INFORMATION THAT IS PROVIDED TO ME IN ORDER TO BE SAFE IN THE HOSPITAL SETTING, AND TO CONTRIBUTE TO THE SAFETY AND WELL-BEING OF PATIENTS, THEIR FAMILIES, OTHER VOLUNTEERS AND STAFF.

Teen Signature _____ Date _____



Volunteer Initiatives
1401 University Hospital
750 E. Adams Street
Syracuse NY 13210

Phone 315-464-5180
Fax 315-464-2272

TEEN VOLUNTEER PARENTAL CONSENT FORM

Parent/Guardian: Please read and check off one or BOTH authorizations below and sign.

- I hereby permit my child, named below, to participate in the Teen Volunteer Program at Upstate Medical University/University Hospital and I permit healthcare providers in Employee/Student Health to:
 - administer a tuberculin skin test
 - provide first aid treatment, if the need arises, during his/her service

- I also permit the volunteer program staff to use photos of my child taken during their volunteer service for internal publications and press releases to area media, for the purpose of program publicity and acknowledgment.

Minor's Name

Date of Birth

Print Parent/Guardian Name: _____

Parent/Guardian Signature: _____

Relationship to Child: _____

Home phone number: _____

Work or cell phone number: _____



SUNY Upstate Medical University

Report of Medical History TEEN Volunteer

____ / ____ / 2008
DATE

LAST NAME	FIRST NAME	MIDDLE INITIAL	____ / ____ / 19	
LOCAL ADDRESS	CITY	STATE	ZIP	PHONE NUMBER
PLACE OF BIRTH	Volunteer Initiatives DEPARTMENT	NY	315 -	- 315 - 464 - 5180
EMERGENCY CONTACT	ADDRESS AND PHONE NUMBER	RELATIONSHIP		
FAMILY PHYSICIAN	ADDRESS	YOUR SOCIAL SECURITY NUMBER		

Please answer each question. If you answer yes to any question, please explain fully:

1. How would you describe your health? _____

2. Any present medical problems? Yes No
3. Any past medical problems or surgery? Yes No
4. Do you taking any medications? Yes No
5. Are you allergic to any medications? Yes No
6. Do you smoke, use alcohol or use any other drugs? Yes No
7. Are there any significant family health problems? Yes No
8. Do you have any limitations or disabilities? Yes No



TEEN

Documentation Requirements for MMR Immunization

Name: _____ Date of Birth: ____/____/____

Provide proof of inoculation for measles/mumps/rubella in one of two ways:

1. Documentation of the administration of two (2) doses of live virus measles vaccine with the first dose administered on or after the age of 12 months and the second dose administered more than 30 days after the first dose but after 15 months of age.

Documentation will include: product administered, date of administration, and it must be issued by health practitioner that administered the immunization.

MMR#1

Vaccine Product

Date of Administration

Signature of HCP who administered.

MMR #2

Vaccine Product

Date of Administration

Signature of HCP who administered.

OR

2. A copy of teen volunteer's childhood immunization record.



**TEEN '08
Allergy Screening**

Name: _____

Date: _____

1. **Do you have allergies?** Yes No

2. **Detail allergies:** _____

3. **Do you have a history of . . .**
contact dermatitis Yes No eczema Yes No rhinitis or conjunctivitis Yes No
hay fever Yes No asthma Yes No autoimmune disease Yes No

4. **Do you have any food allergies?** NONE Circle if positive
banana fig peaches avocado nectarine tomato papaya plum potato kiwi cherry chestnuts passion
fruit melons milk

5. **Have you ever had an allergic reaction to latex products?** NO, Circle all which apply
balloons, belts, bras, suspenders, ostomy bags, rubber gloves, cuffs, elastic waistbands, IV tubing
hot water bottles, adhesive tape, ACE bandages, Band-Aids, rubber cement, carpet backing, rubber bands,
balls, latex birth control devices, weather stripping, foam rubber, dental cofferdams, garden hose,
baby bottle nipples, dental masks, rubber tennis/golf grips, pacifiers, teething rings, face masks, erasers
other: _____

6. **After handling latex products, have you experienced . . .** Circle all which apply
redness, dermatitis, hives, itching (hands, eyes, etc.), swelling, runny nose/congestion, difficulty breathing
other: _____

7. **History of latex reactions or undiagnosed reactions during medical or dental work.** Yes No
If yes, explain incidence: _____

8. **Does your occupation involve exposure to latex or rubber?** Yes No
If yes, what latex products do you work with? _____

9. **Will this employment involve direct or indirect contact with animals or animal products?** Yes No
If yes, which species will you have contact with at work: Circle all which apply
Mice, Amphibians, Rats, Dogs, Hamsters, Cats, Non-human parts, Guinea pigs
Pigs, Gerbils, Sheep, Rabbits, Goats

10. **Comments and Recommendations:**



University Hospital
Teen Volunteer Recommendation Form
Summer, 2008

TEEN APPLICANT: Fill out the top portion of this form before you give it to the adult who will give you a recommendation. Please ask that you receive it in a sealed envelope with their signature across the seal in time to submit with your application materials.

Student's name: _____

Student's grade (Fall, 2008): _____

I give you permission to release the following confidential information to the Department of Volunteer Initiatives at University Hospital.

Signed (Student) _____

TO THE RECOMMENDER: The person named above is applying to the Teen Volunteer Program at University Hospital. We would appreciate your insight about his/her responsibility, dependability and maturity. Please contribute any comments or observations that would help us make a thoughtful decision about this candidate's participation. See instructions in the top portion of this form.

Name: _____ Phone: _____

Your relationship to the teen volunteer applicant? _____

How and how long have you known him/her? _____

Is s/he dependable? Provide examples/comments: _____

Does s/he act appropriately around adults and peers? Provide examples/comments: _____

The program requires a minimum 50 hour commitment over the summer. Do you feel that this student can honor the commitment? Any comments? _____

Please comment on any of this candidate's qualities that you feel would/would not contribute to his/her successful experience as a hospital volunteer: _____

Please select one:

highly recommend recommend do not recommend for the volunteer program at University Hospital

Signature: _____ Date: _____

Please put this form in a sealed envelope, sign across the seal and return to the applicant.

Thank you
Volunteer Initiatives
315-464-5180
www.upstate.edu/u/volunteers/



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