Hillcrest Hospital
a Cleveland Clinic hospital

JUNIOR VOLUNTEER APPLICATION

Last _____ First _____ Middle _____ Date _____

Address _____ City _____ State _____ Zip _____

Birth date _____ Home Phone ( ) _____

Social Security Number _____ Parents' Name _____

Name of school _____ Grade (circle) 9 10 11 12

Graduation Year _____ Career Interest _____

Favorite Subjects and Grades _____

School Counselor _____ Phone No. _____

Present Employment _____

Work Hours _____ Work Phone _____

How did you learn about the Junior Volunteer Program? _____

_____

Are you interested in volunteering because you need to perform community service hours? Yes _____ No _____

If yes, please explain why you need to perform them and how many hours are required _____

_____

IN AN EMERGENCY PLEASE NOTIFY

Name: _____ Relationship: _____

Address: _____

City: _____ State _____ Zip _____

Home Phone ( ) _____ Work Phone ( ) _____

Student's Signature _____

Parent's Signature _____

Your signature indicates your approval for your child's participation in the teen program

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PARENTAL CONSENT FORM

My child _____ has permission to volunteer at Hillcrest Hospital.

I understand that in the course of volunteering, depending on the area assigned, my child may be exposed to Bio Hazardous materials and infectious waste. These are substances that are potentially dangerous to health and safety. These hazards may include disease-causing organisms, human body fluids, and sharps (needles and syringes).

Your child will be instructed in proper procedures to protect themselves and others from these materials.

Signature of Parent or Legal Guardian | Relationship | Date

EMERGENCY TREATMENT AUTHORIZATION

Purpose: To enable parents and legal guardians to authorize emergency treatment for children under 18 years of age who become ill or injured when parents or guardians cannot be reached.

Child's Name: _____

Telephone Number

Address: _____

Family Physician: _____

I _____ (parent/legal guardian) of _____

hereby grant permission to _____ Hospital and the Emergency Department physician

to administer any emergency treatment as deemed necessary.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians, concurring the necessity for such surgery, are obtained prior to the performance of such surgery.

_____

Signature of Parent or Legal Guardian Date

Child's Allergies: _____

Child's Chronic Illness: _____

Comments: _____

_____