BAPTIST HEALTH®

HARDIN

2024 VolunTEEN Program

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HARDIN

Dear VolunTeen Applicant,

We are pleased that you have chosen Baptist Health Hardin as a potential place of service. We hope to have a great group of excited, compassionate, and committed teens working with our exceptional adult volunteers and staff!

Enclosed in this packet, you will find essential forms you must complete for the program:

1. VolunTEEN application
2. VolunTEEN guidelines
3. VolunTEEn criteria
4. Parental Consent to Tretment of Minor
5. Parent/Guardian Permission Form
6. Medical Awareness List
7. VolunTEEN schedule preferences
8. HIPAA Security Acknowledgement

Please read over the information very carefully and be sure to complete all forms. If the information is not filled out completely, we cannot process the application. Remember to bring all signed papers with you to orientation. If you have any questions, please contact me at 270-706-1713 or patricia.howell3@bhsi.com.

Thank you and we look forward to seeing you soon!

Sincerely,

Pat Howell

Pat Howell, Volunteer Coordinator

BAPTIST HEALTH HARDIN AUXILIARY
APPLICATION FOR VOLUNTEEN SERVICES

Name _____ Date _____

Name which you prefer to be called _____

Street _____

City _____ State _____ Zip _____

Home Phone Number _____ Cell Phone Number _____

E-Mail Address _____Age ____ Birthday _____

School you will be attending _____

Are you interested in a medical career? ___ What field? _____

Have you ever done any volunteer work? _____ Where _____

What kind of volunteer work are you most interested in?
Patient Escort___ Information Desk ____ Clerical ____ Gift Shop
Same Day Surgery ____

Tee Shirt Size _____ Do you drive? _____

VOLUNTEER GUIDELINE

1. **Sign in and out daily and wear your Baptist Shirt and badge.**

2. **Upon arrival, report to the person in charge of your designated area.**

3. **Do NOT sit or ride in wheelchairs or on stretchers!**

4. **Do NOT invite friends to the hospital to visit you while you are volunteering.**

5. **ALWAYS inform the person in charge whenever you must leave your assigned area and when you leave at the end of your assigned shift.**

6. **Do NOT leave the hospital at any time while you are volunteering.**

7. **Cell phones are put up and out of sight while students are volunteering at Baptist Health Hardin.**

8. **Enter only those areas of the hospital to which you are assigned or instructed to go.**

9. **Do not chew gum while in the hospital and keep food and drink confined to the cafeteria and break areas.**

Teen/Junior Volunteer Criteria

Age:	Must be 14 years of age and freshmen or above (copy of birth certificate)
Parental Consent Form:	Parental Consent form allowing for participation in Volunteer Program
Reference/Recommendation:	Recommendation form from a current teacher, counselor or principal, must be completed
Volunteer Application:	Volunteer must complete application
Orientation:	Must attend a Teen Volunteer Orientation Class prior to volunteering
Volunteer Schedule:	Must be willing to commit to a minimum of one shift per week…3 hours per day in year round program and 4 hours per day in summer program
Health Records:	Must provide a copy of immunization records. Annual TB Skin testing.
Grade:	Must maintain at least a B average and provide copy of a current report card
Dress Code:	Purchase and wear teen volunteer polo shirt with pants or skirt. Close toed shoes and socks/hosiery must be worn. Photo ID badge must be worn at all times when volunteering. No denim is allowed nor pants/shirts with rivets.
Volunteer Times:	When school is in session teen volunteer hours would be no earlier than 4pm and no later than 8:30pm, Monday through Friday, between 9:00am and 5:00pm on Saturday and 1:00pm to 5:00pm on Sunday. When school is out of session teen volunteer hours would be no earlier than 8:00am and no later than 8:30pm, Monday through Friday, between 9:00am and 5:00pm on Saturday and 1:00pm to 5:00pm on Sunday. When school is in session many positions would be 4:00pm to 7:00pm. The hours are dependent on the department/area. Assignments are made on a set schedule (example: each Monday at Main Entrance Desk from 4:00pm to 7:00pm).

BAPTIST HEALTH HARDIN
VolunTEEN PROGRAM

PERMISSION FORM

This is to be completed and signed by a parent or legal guardian ONLY.

I, _____ (parent/guardian's name) give permission for my child, _____ (child's name) to volunteer at Baptist Health Hardin. I will ensure his/her transportation to and from the hospital. I understand that he/she cannot arrive at the hospital more than 30 minutes prior to his/her assigned volunteer shift(s) and must be picked up promptly at the end of the volunteer shift. I also understand that VolunTEENs are not allowed to leave their department unless approved by authorized personnel. I further understand that VolunTEENs may not leave the Baptist Health Hardin campus for lunch or any other reason unless expressly approved by the parent/guardian.

_____
Signature of Parent/Guardian

_____
Date

_____
Signature of VolunTEEN

_____
Date

BAPTIST HEALTH HARDIN

HIPAA SECURITY

I, _____ (please print) acknowledge and agree to abide by the Baptist Health Hardin, HIPAA Security policies and procedures and the specifications within the above and attached documents whereas they pertain to HIPAA Security. I realize that there are civil and criminal penalties for the unauthorized use of and disclosure of confidential medical information and electronic protected health information.

VolunTEEN Signature:

_____ Date: _____

VOLUNTEEN CONTACT INFORMATION DATE _____

Please Print:

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

TELEPHONE _____ CELL PHONE _____

IN CASE OF EMERGENCY:

NAME _____ RELATION _____

ADDRESS _____

CELL NUMBER _____WORK NUMBER _____

NEXT OF KIN NOT LIVING IN YOUR HOUSEHOLD:

NAME _____ RELATION _____

ADDRESS _____

CELL NUMBER _____ WORK NUMBER _____

FRIEND WHO WOULD KNOW WHERE YOU ARE:

NAME _____ RELATION _____

ADDRESS _____

CELL NUMBER _____ WORK NUMBER _____

Contact Pat Howell at 270-706-1713 with questions/concerns.

Areas/Types of Teen Volunteer Opportunities

OSEC Information Desk – greeting guests, provide room numbers, directions, escorting

Emergency Department Entrance – greeting guests, directions, escorting

Patient Access Information Desk – greeting guests, provide room numbers, directions, escorting

Main Information Desk – greeting guests, provide room numbers, directions, escorting, deliveries (flowers, etc)

Gift Shop – (At least 16 years of age and would always volunteer with an Adult Volunteer) – greeting customers, sales, stocking, pricing, cleaning

Magazine Cart – Deliver magazines to patients, waiting rooms, lobbies, etc

Inpatient Unit Volunteers (16 years or older) – answer call lights and alert staff of patient needs, fill ice pitchers, stock door caddies, run errands, assist visitors and family

Patient Financial Services (summer only) – clerical duties, run errands

Tuberculosis (TB) Risk Assessment

Name: _____ *Date of Birth:* _____

Home/Work/Cell Phone: _____ *Department:* _____

County of Residence: _____

***Instructions: Complete the following sections, sign and date, and forward this completed form along with any previous TB documentation* to the Employee Health Services office.**

Phone 270-706-1179 Fax 270-706-5030

Screen for ACTIVE TB Symptoms
(check all that apply to you)

__ Cough for > 3 weeks → Productive? __ Y __ N
__ Coughing up blood
__ Fever of 100°F (or 38°C) for over 2 weeks
__ Unexplained weight loss > 10 lbs.
__ Poor appetite
__ ***Unusual*** or heavy sweating at night
__ ***Unusual*** weakness or extreme fatigue
__ N/A

Comments (Explain any checks):

Screen for Risk of Developing TB Disease
(check all that would apply to you)

__ HIV positive
__ Risk for HIV infection/HIV status is not known
__ Inject drugs that are not prescribed by doctor
__ A history of TB, without finishing treatment
__ 10% below ideal body weight
__ Currently taking immunosuppressive medications such as: Methotrexate, Remicade, Humira, etc.
__ Current use of alcohol and/or tobacco
__ Have or have had any of the following medical conditions (circle all that apply):

Diabetes — Kidney Disease
HIV infection — Colitis
Cancer — Stomach or intestine surgery
Rheumatoid Arthritis

__ N/A

Screen for TB Infection Risk
(check all that apply to you)

__ Have lived or spent time with someone who has been sick with TB
__ Have been in another country for 3 or more months where TB is common, and have been in the US for less than 5 yrs.
__ Have injected drugs that your doctor has not prescribed.
__ Have lived or worked in the following: prison, jail, homeless shelter or long term care facility.
__ N/A

Comments:

History of TB Testing
(check all that apply to you)

__ History of BCG Vaccine (If yes, what year:_____)
__ Previous Positive TB test (If yes, what year: _____)
Circle type: TB Skin Test, TSPOT, Q-Gold
__ Chest X-Ray within previous two months
Circle Chest X-Ray result: Normal or Abnormal
__ Have taken TB Medication (If yes, what year:_____)
__ Completed TB Medication
__ N/A

Comments:

I hereby certify that the information is true and complete, to the best of my knowledge. I understand that this information will remain a part of my employee health record and will not be released without my knowledge and written consent except for new findings which are required to be reported to the local health department having jurisdiction.

The Tspot will include a venous blood draw I am aware that this procedure always has some degree of associated risk of bleeding, bruising or infection. The data obtained from the Tspot is to be considered preliminary and is in no way conclusive.

I have read and understand the above statements. I hereby agree to indemnify, save and hold harmless Baptist Health Hardin, its employees, agents and servants, from any loss, liability or personal injury relating to the Tspot tests or the data derived from the results. The undersigned further expressly agrees that the foregoing release, waiver and indemnity agreement is intended to be as broad and inclusive as is permitted by the laws of the Commonwealth of Kentucky. I have read and voluntarily sign the Release and Waiver of Liability and Indemnity Agreement, and further agree that no oral representations, statements or inducements, apart from the foregoing written agreement have been made.

_____ Signature

___/___/_____ Today's Date

For Employee Health Use Only
Reviewed by: _____
Date Health Department Notified: ___/___/_____

MEDICAL AWARENESS LIST

This form is for your safety in the event of an emergency and is confidential.

Medical Condition		Medication if Needed	Dosage
Asthma			
Blood Pressure			
Diabetes			
Epilepsy			
Headaches			
Respiratory			
Seizures			
Other:			
Note:			

PLEASE LIST ANY KNOWN DRUG ALLERGIES

Printed Name _____

Signature _____ **Date** _____

BAPTIST HEALTH®

Release for Photography, Videography and Audio Recording/ Authorization to Release Protected Health Information

Place barcode sticker here

I hereby grant my permission to be interviewed and/or photographed, videotaped or audiotaped by a representative of the news media, Baptist Health, or _____ [insert name of other party wishing to photograph or interview]. I further grant permission to publish the broadcast, interview, photograph, and/or audio recording of me and/or the minor patient or person named below for whom I am giving consent, as described below and for educational, advertising, marketing, fundraising, promotional or public relations purposes. I further waive all rights to receive or collect royalties, proceeds or profits related to such broadcast and/or publication.

I agree to release and hold harmless Baptist Health, its directors, officers, agents, and employees from any and all injuries, damages or liability that may arise, directly or indirectly, from my participation in the interview or photographs and from the use of anything I may say or do during said recordings, photography and/or interview. I understand that I have the right to request that filming or recording stop at any time. I also have the right to rescind (or withdraw) my authorization up until a reasonable time before the recording, filming or photo is used.

I have read this authorization and release before signing below and have had the opportunity to ask questions. I represent that I fully understand its contents.

I, the undersigned hereby authorize and direct ❑ Baptist Health
❑ Baptist Health Corbin ❑ Baptist Health La Grange ❑ Baptist Health Lexington ❑ Baptist Health Louisville
❑ Baptist Health Madisonville ❑ Baptist Health Paducah ❑ Baptist Health Richmond ❑ Baptist Health Floyd
X Baptist Health Hardin ❑ BHMG office practice name and address: _____
and its entities, authorized agents and employees to disclose and deliver a copy of the protected health information described below in accordance with this authorization.

Name (please print):	
Which best describes you: ❑ Employee ❑ Physician/provider ❑ Patient X Other: Volunteen	
Address:	E-Mail:
Date of interview or filming:	
Purpose of interview or filming:	
❑ Permission to publish use across multiple channels (online, social media, print, TV, radio, podcast). If not, describe use:	
Notes/Special Instructions:	
Photographer/Company name and address:	
If patient: I acknowledge any information I share during filming or taping, including the medical condition for which I am being filmed or taped, will be disclosed. I understand no other information from my Medical Record will be accessed or made public. I understand that this Authorization will expire upon the occurrence of the following event or condition: _____. If no event or condition is listed, this authorization will expire in 60 days. I understand that I have the right to revoke this Authorization at any time, and in order to do so, I must present a written revocation to the Marketing department for the above checked Baptist Health facility. I understand that the revocation will not apply to information that already has been released in response to or in reliance upon this Authorization. In this case, reliance may mean that the recipient has filmed, photographed or recorded my voice or image. I understand that I need not sign this Authorization in order to ensure healthcare treatment, payment, enrollment in my health plan, or eligibility for benefits. I understand that I will be given a copy of this Authorization form after signing it. If Provider/Staff: I acknowledge I have been educated on all HIPAA guidelines and will comply with these during filming.	
Signature:	Date:
Parent/Guardian/Power of Attorney:	Date:
Witness:	Date: