St. Elizabeth Hospital
AFFINITY HEALTH SYSTEM

STUDENT/PARENT/GUARDIAN AGREEMENT

- STUDENT APPLICANT NEEDS TO COMPLETE THE FIRST SECTION.
- IF STUDENT APPLICANT IS UNDER THE AGE OF 18 OR REQUIRES LEGAL GUARDIANSHIP PARENT/GUARDIAN NEEDS TO COMPLETE THE SECOND SECTION.

Student Section:

Student Name: (Please print) _____ Email: _____

- ❖ I am aware that High School students new to the St. Elizabeth Hospital Volunteer Program are accepted into the program only in the spring for the summer program. After completion of one summer, I may apply for a volunteer opportunity during the school year.

- ❖ I am aware that the summer volunteer program is an eleven week program and I must commit to a minimum of eight weeks. Following the summer program I am aware the commitment to participate is by semester. (September – December & January – May). I further understand that my service hours will not be validated/verified for employment or scholarship recommendations, secondary education application forms and/or other forms of reference letters in the event I volunteer 30 hours or less.

- ❖ I understand that volunteer assignments are scheduled on a regular basis and I am expected to report as assigned or follow the procedures for finding a substitute.

- ❖ I understand that if I do not abide by the policies and procedures of St. Elizabeth Hospital or if I have three (3) or more **unexcused** absences I may be terminated from the Volunteer Program. *(An unexcused absence would occur if I do not call or simply do not show up for my shift. I understand that a 24-hour advance of my unavailability is expected if at all possible.)*

- ❖ I understand that volunteering is a serious commitment and I will report on time dressed in appropriate attire (no jeans, shorts, short skirts, or flip flops) and will report only on the day/s assigned. *(Volunteers will be sent home if dressed inappropriately or not wearing their uniform vest or name badge.)*

- ❖ I understand that there is the possibility that I may not be accepted in to the Volunteer Program at this time if there is no appropriate position available.

- ❖ I am aware that as a St. Elizabeth Hospital volunteer, I represent not only myself, but my school and St. Elizabeth Hospital, and I must demonstrate appropriate behaviors at all times when on duty or will be subject to dismissal if deemed necessary.

- ❖ I will maintain confidentiality concerning patients, their families and organization information and understand that a breach in confidentiality may result in termination.

- ❖ I will ensure that I meet all necessary requirements on or before the deadlines that include: setting up and completing appointments for the interview, health work, orientation, and all required paperwork.

- ❖ I wish to donate my time to St. Elizabeth Hospital and understand there is no payment for services rendered through the Volunteer Program.

Parent/Guardian Section:

To be completed by the parent/guardian if applicant is under the age of 18 or requires legal guardianship.

- Having an understanding of the expectations of the program I have reviewed this form with my son/daughter/minor. I support their commitment to volunteer at St. Elizabeth Hospital and I give permission for my son/daughter/minor to participate in the volunteer program. I agree to help my son/daughter/minor be reliable and report promptly for his/her shift.

- I certify that he/she is _____ years of age. Birth date : ____/____/_____

- I authorize the necessary care and treatment of my son/daughter/minor in the event of a medical emergency.

- I authorize any screening that is required by Affinity Health System for participation in the volunteer program. This may include a TB skin test/s, a flu vaccine, and a lab draw to test for immunities to mumps, measles, rubella and varicella (chicken pox). I also give permission for any future TB skin tests, lab draws or flu vaccines.

Any questions or clarifications regarding health work can be discussed with the St. Elizabeth Hospital Associate Health Nurse at the time of the applicants health appointment.

Your signatures on this agreement will serve as your acknowledgement of the requirements of St. Elizabeth Hospital's Student Volunteer Program and required authorizations as listed above. If you have any questions or concerns, please do not hesitate to contact Volunteer Services at 920.738.2425. We anticipate that our student volunteers will have a rewarding and positive experience at St. Elizabeth Hospital.

(Please return this signed copy to the Volunteer Services department and keep an additional copy for your records.)

_____ _____

Student Signature *Date*

_____ _____

Parent Signature *Date*

Please return your completed Student/Parent/Guardian Agreement

Fax: 920.831.8938 **Email: seh.volunteer.svcs@affinityhealth.org**

Mail or Hand Deliver to: St. Elizabeth Hospital, Volunteer Services, 1506 S Oneida Street, Appleton, WI 54915

For questions please call the Volunteer Services department 920.738.2425

Once your paperwork is received, you will be contacted regarding your interests. 2016-01-20