

2022 VolunTEEN Packet

NAME: _____ **GRADE:** _____

EMAIL: _____ **PHONE #:** _____

GUARDIAN'S EMAIL: _____

POLO SIZE: S M L XL XXL

Indicate your preference of shift by numbering the blocks below by 1st, 2nd and 3rd choice. If you have multiple first choices, put a number "1" in each shift you are able to work. If you are flexible and do not have any preferences, indicate that as well!

We will do our best to accommodate your preferences.

Shifts at Egleston, Hughes Spalding, and Scottish Rite are from 9am-12pm or 12pm-3pm, Monday through Friday. **We DO NOT offer any weekend placements.**

SHIFT	9AM-12PM	12PM-3PM
MONDAY		
TUESDAY		
WEDNESDAY		
THURSDAY		
FRIDAY		

Make certain that the eight-week session (June 6th – July 29th) does not conflict with any plans (i.e. vacation, band or camp) that you may have for the summer. You must be available for those eight weeks, missing no more than two shifts with prior notice. July 4th will be recognized as a holiday and will not count as an absence for VolunTEENs assigned to Monday.



VolunTEEN Agreement

I, _____, hereby agree to the following:

I understand volunteers must be at least 15 years old by June 1, 2022 and must fulfill all Volunteer Services requirements before placement can occur.

I will attend the required training in order to be involved in the VolunTEEN Program for the summer of 2022. I will notify the Volunteer Services office staff if I will be unable to attend.

I will keep confidential any information that I obtain while in the hospital. I acknowledge that anything seen or heard while in the hospital is privileged and should not be repeated. I understand that any breach of confidentiality will cause my volunteer status to come under review by the Volunteer Services office.

I agree to maintain the volunteer standards of Children's Healthcare of Atlanta. I acknowledge that Children's reserves the right to end my volunteer placement if these standards are not met, following a conference with a member of the Volunteer Services staff.

I agree to have a TB (T-Spot) blood draw test. This test will be offered free of charge at Children's on assigned clinic dates. I understand that if I do not turn in a completed TB blood draw test, I will not be permitted to volunteer on the first day and it will count as one of my two absences.

I agree to wear the uniform required for my volunteer placement. The VolunTEEN uniform is a Children's Healthcare of Atlanta VolunTEEN Polo Shirt. It is to be worn with long khaki pants/skirt (no capris or shorts). I understand that if I am not wearing the proper attire I may be sent home to change.

I agree to be assigned to a shift one day per week based on the needs of my assigned location. I understand that I must volunteer at least six of my eight shifts.

I agree to notify the Volunteer Services office of any unplanned absences.

I understand that my volunteer placement may be ended if I am absent without notification.

Signed: _____ Date: _____
Prospective VolunTEEN

Signed: _____ Date: _____
Parent/Guardian



CONSENT FORM AND WAIVER (PATIENT & FAMILY)

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH AND OTHER PERSONAL INFORMATION AND/OR PUBLIC USE OF IMAGE (PHOTOGRAPH OR VIDEO) FORMARKETING PROMOTION, MEDIA AND PUBLIC RELATIONS PURPOSES

I hereby give consent to Children’s Healthcare of Atlanta Inc. (hereinafter “Children’s”), its affiliates, media outlets, community organizations, and/or third parties providing service to Children’s to take and use images (photographs or video) or sounds recordings of me and/or the minor patient/person named below for whom I am giving consent (hereinafter the “Patient”), and to disclose such information in any Children’s and/or third party media outlet, including radio, television, internet, social media, or print. I understand that the intended use of such images and information may be for advertising, marketing, fundraising or promotional purposes of Children’s.

I understand that the information to be disclosed may include protected health information about the Patient’s treatment at Children’s obtained from interviews of the family, physicians and hospital personnel, or from the patient’s medical records. I hereby waive the right to or interest in the confidentiality of this information or images taken and disclosed to the public, as contemplated in this release. I understand that the information disclosed pursuant to this release may be re-disclosed and no is longer protected by any federal or state privacy regulations.

I acknowledge that this consent and authorization for release of confidential information is being made solely for the benefit of Children’s and without any expectation of compensation or other benefit to the Patient or the family thereof. While unlikely, Children’s may receive direct or indirect remuneration from a third party. To the extent that any benefit accrues or might accrue to Children’s from the use of images or disclosure of information, I hereby and forever waive any interest in or claim to such benefits.

I hereby release and forever discharge Children’s (including without limitation all corporate affiliates and officers, directors, trustees, employees, medical staff members and agents) from any and all claims, liability, actions, suits, demands, costs, expenses or indebtedness arising out of, related to, or in any way connected with the use of images or disclosure of the information and materials described herein, and I hereby waive all rights and interest in and to such information and materials.

I understand that I may refuse to sign this authorization, that it is strictly voluntary and that my treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this release. I have been informed that this authorization is voluntary and is subject to revocation at any time, except to the extent that action has been taken in reliance thereon, by notifying Children’s in writing at: MediaConsents@choa.org.

Expiration:

Authorization is ongoing until Patient reaches age of majority (18yo) unless otherwise revoked.

Date

Patient Name or Name of Minor (please print)

Patient or Minor Date of Birth

Name of Parent/Legal Guardian/Patient if 18 or older

Relationship to Patient

Signature of Parent/Legal Guardian/Patient if 18 or older

Phone Number

Zip code

Email address

*Completed paper forms must be inputted into online consent portal at choa.org/consent by Children’s employee **within 24 hours**. Paper forms should be hand-delivered or sent via interoffice mail to Public Relations Team at 1575 Northeast Expressway **within three business days**.

Recommendation Form

Dear Advisor/ Professor/ Supervisor/ Coach:

_____ has applied to the VolunTEEN Program at Children's Healthcare of Atlanta. Thank you for taking the time to complete this evaluation. Your observations are an important part of this student's application. Please comment on the following areas:

Self-sufficient	<input type="radio"/> Always self-sufficient	<input type="radio"/> Usually self-sufficient	<input type="radio"/> Sometimes self-sufficient	<input type="radio"/> Rarely self-sufficient	<input type="radio"/> N/A
Respect for others	<input type="radio"/> Always respectful	<input type="radio"/> Usually respectful	<input type="radio"/> Sometimes respectful	<input type="radio"/> Rarely respectful	<input type="radio"/> N/A
Ability to work independently	<input type="radio"/> Always works well	<input type="radio"/> Usually works well	<input type="radio"/> Sometimes works well	<input type="radio"/> Rarely works well	<input type="radio"/> N/A
Ability to work with others	<input type="radio"/> Always works well	<input type="radio"/> Usually works well	<input type="radio"/> Sometimes works well	<input type="radio"/> Rarely works well	<input type="radio"/> N/A
Takes initiative	<input type="radio"/> Always	<input type="radio"/> Usually	<input type="radio"/> Sometimes	<input type="radio"/> Rarely	<input type="radio"/> N/A
Attendance	<input type="radio"/> Excellent	<input type="radio"/> Good	<input type="radio"/> Fair	<input type="radio"/> Poor	<input type="radio"/> N/A
Timeliness	<input type="radio"/> Always on time	<input type="radio"/> Usually on time	<input type="radio"/> Sometimes on time	<input type="radio"/> Rarely on time	<input type="radio"/> N/A
Friendliness	<input type="radio"/> Always Friendly	<input type="radio"/> Usually Friendly	<input type="radio"/> Sometimes Friendly	<input type="radio"/> Rarely Friendly	<input type="radio"/> N/A
Responsible	<input type="radio"/> Always Responsible	<input type="radio"/> Usually Responsible	<input type="radio"/> Sometimes Responsible	<input type="radio"/> Rarely Responsible	<input type="radio"/> N/A
Concern for others	<input type="radio"/> Always considerate	<input type="radio"/> Usually considerate	<input type="radio"/> Sometimes considerate	<input type="radio"/> Rarely considerate	<input type="radio"/> N/A
Communication skills	<input type="radio"/> Excellent	<input type="radio"/> Good	<input type="radio"/> Fair	<input type="radio"/> Poor	<input type="radio"/> N/A
Receptive to feedback	<input type="radio"/> Excellent	<input type="radio"/> Good	<input type="radio"/> Fair	<input type="radio"/> Poor	<input type="radio"/> N/A
Integrity	<input type="radio"/> Very trustworthy	<input type="radio"/> Trustworthy	<input type="radio"/> Sometimes trustworthy	<input type="radio"/> Rarely trustworthy	<input type="radio"/> N/A

Overall Recommendation (circle): Strongly Recommend Recommend Do not recommend

Additional Comments:

Evaluator's Name (please print): _____ **Phone:** _____

Title: _____ **Email:** _____

Evaluator's Signature: _____ **Date:** _____

Please place this form in a sealed and signed envelope and return to applicant. Thank you!



DISCLOSURE AND AUTHORIZATION REGARDING OBTAINING CONSUMER AND/OR INVESTIGATIVE REPORTS FOR VOLUNTEERING AT CHILDREN'S

In considering your application for volunteering, *Children's Healthcare of Atlanta*, because of its obligation to provide a safe environment for patients and families, may request that a consumer-reporting agency prepare a consumer report or investigative report regarding you. In addition, Children's may independently conduct background checks on you. The consumer report, investigative report and/or background check may include, but not be limited to, information regarding your credit history, criminal convictions, former employers, education and/or training.

1. By signing this disclosure, you consent to Children's obtaining a consumer report and/or investigative report on you and further consent to Children's independently conducting a background check on you.
2. By signing this disclosure, you acknowledge that you
 - a) Have received a copy of this disclosure.
 - b) Have been notified of the possibility that a consumer and/or investigative report will be prepared.
3. In accordance with the federal Fair Credit Reporting Act, if an investigative report is requested, you have the right to request that Children's completely and accurately disclose to you the nature and scope of any requested report.

By signing the acknowledgement below, I release Children's from any and all liability relating to or arising from such consumer reports and/or investigative reports and/or background checks. I acknowledge that I have read this entire document and understand the same.

Applicant's Signature _____
Date

PRINT Full Name (First, Middle, Last)

Street Address

City _____ _____
State _____ _____
Zip

Social Security Number _____ _____ _____
Sex _____ _____ _____
Race _____ _____ _____
Date of Birth

VolunTEEN 2022
KEEP FOR YOUR RECORDS
(Do not include in packet)

The VolunTEEN Packet must be received **ALL TOGETHER** in a sealed envelope by 4:30 p.m. on Friday, February 11th. All paperwork must be received for the application to be considered complete. In addition to the paperwork listed below, all applicants must also complete the online application at www.choa.org/volunteen.

All applicants will be notified by March 18th of their application status.

COMPLETION CHECKLIST:

- Completed Online Application
- VolunTEEN Packet
- Teacher/Counselor Recommendation Form – must be submitted in a signed and sealed envelope
- Immunization Record
 - Chicken Pox (Varicella – 2 shot series OR titer blood test showing immunity)
 - MMR (Measles, Mumps, Rubella – 2 shot series OR titer blood test showing immunity)
 - Tdap (Tetanus, Diphtheria, Pertussis – 1 shot, must have received within in the last 10 years)
 - Proof of COVID-19 vaccination
- Copy of Photo I.D. (Driver's license, school ID, passport, etc.)
- Background check disclosure form (if above the age of 18)

If titer blood test does not show sufficient immunization for these diseases, appropriate vaccination(s) are required.

If accepted, note that there will be a **mandatory** training at the campus at which you applied:

Children's at Egleston:

Wednesday, June 1st at 2:00pm – 3:30pm

Children's at Hughes Spalding:

Wednesday, June 1st at 2:00pm – 3:30pm

Children's at Scottish Rite:

Thursday, June 2nd at 2:00pm – 3:30pm

Mail or hand deliver this packet to the campus at which you applied.

As a reminder, you are only able to apply to ONE campus:

<u>Children's at Egleston</u> Volunteer Services 1405 Clifton Road NE Atlanta, GA 30322	<u>Children's at Hughes Spalding</u> Volunteer Services 35 Jesse Hill Jr. Drive SE Atlanta, GA 30303	<u>Children's at Scottish Rite</u> Volunteer Services 1001 Johnson Ferry Road NE Atlanta, GA 30342
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