Baptist Memorial Hospital-Golden Triangle

Summer Teen Volunteer Program

Do you have an interest in healthcare as a career?
Do you like to help others in your community?
Do you need Community Service hours to graduate?
Become a Summer Teen Volunteer at BMH-GT!

Requirements:

- ✓ You must be 16 years old on or before January 1st, 2014.
- ✓ Complete an application, provided by your school counselor, and submit to BMH-GT Volunteer Services.
- ✓ Complete the interview process.
- ✓ Upon acceptance into the program, receive the required Tuberculin Skin Test Injection, which will be administered by Baptist Memorial Hospital-Golden Triangle.
- ✓ Attend Orientation when scheduled.
- ✓ Deadline for applications is Friday, April 4, 2014.

Space is limited, so get your application completed and submitted today!

2014 SUMMER TEEN VOLUNTEER APPLICATION

Baptist Memorial Hospital-Golden Triangle Volunteer Services
2520 5th Street North~ Columbus, MS 39705

DEADLINE FOR RECEIPT OF APPLICATION: FRIDAY, APRIL 4, 2014

Please read carefully and PRINT neatly.

Last Name: _____ First Name: _____ MI: ____

Address: _____ City: _____ State: _____ Zip: _____

Cell Number: _____ Social Security Number: _____

Date of Birth: _____ Age: _____ Gender: ☐M ☐F

Parent/ Guardian Name: _____Telephone #: (___)_____

Parent/ Guardian Work #: _____ Grade Attending in Fall: _____

School Attending in the Fall:_____ School Counselor: _____

Are you a Returning Teen Volunteer? Yes _____ No _____

If yes, which departments did you work in? _____

_____

Have you ever worked in an office? Yes _____ No _____

Does anyone in your family work at BMH-GT? Yes _____ No _____

If yes, name of family member and department they work in:

_____

Men's T-Shirt Size: ___XS ___S ___M ___L ___XL ___2X ___3X

BMH-GT IS REQUIRED TO GIVE AN INJECTION OF THE TUBERCULIN SKIN TEST TO STUDENTS AFTER ACCEPTANCE INTO THE SUMMER TEEN PROGRAM. A PARENT'S PRESENCE AND SIGNATURE WILL BE REQUIRED IN ORDER FOR THE STUDENT TO RECEIVE THE TB SKIN TEST.

Applications must be complete for submission. Incomplete applications will not be considered for the program. There will be no exceptions made after the deadline.

Return application by mail, fax or email to: Cathy Johnson, BMH-GT Volunteer Services
P. O. Box 1307~ Columbus, MS 39703-1307
Email: cathy.johnson@bmhcc.org

TEEN MEDICAL INFORMATION

NAME: _____

SEX: ☐ M ☐ F DATE OF BIRTH: _____

FATHER'S NAME: _____ MOTHER'S NAME: _____

WORK ADDRESS: _____

PHONE NUMBER: _____

HOME ADDRESS: _____

HOME PHONE: _____

OTHER PERSON TO CONTACT FOR EMERGENCY: _____

RELATIONSHIP: _____ PHONE NUMBER: _____

INSURANCE NAME: _____

POLICY AND GROUP NUMBER: _____

ALLERGIES: _____

_____

ARE THERE ANY MEDICAL CONDITIONS THAT YOUR CHILD HAS THAT WE NEED TO KNOW ABOUT? _____

_____

_____

_____

_____ _____

Signature of parent or guardian Signature of applicant

_____

Date

MEDICAL AUTHORIZATION FORM

Child's Name: _____ Sex: _____ Birthday: _____

Address: _____ City: _____ State: _____ Zip _____

Parent/Guardian: _____ Home Phone: _____

Work Phone: _____

Emergency Number(s): _____

HEALTH HISTORY (Check – giving approximate dates)

Ear Infections	_____	Chicken Pox	_____	Allergies:	
Rheumatic Fever	_____	Measles	_____	Hay Fever	_____
Convulsions	_____	German Measles	_____	Poison Ivy	_____
Diabetes	_____	Mumps	_____	Penicillin	_____
Behavior	_____	Asthma	_____	Other Drugs	_____

Dates of last tetanus booster _____

Operations or serious injuries _____

Chronic or recurring illness _____

Restrict activities _____

MEDICATION:

The following medications may be administered to my child:

Aspirin	_____	Alka Seltzer	_____	Benadryl	_____
Tylenol	_____	Kaopectate	_____	Other	_____
Pepto Bismol	_____	Dramamine	_____		

Medicines in student's possession _____

Medical Insurance (Company) _____

(Name of insured) _____ (Policy/Group #) _____

PARENT'S AUTHORIZATION: In the event I cannot be reached in an emergency, I hereby authorize _____ or _____ or their designate to hospitalize, secure proper treatment for, and to order injection, to the proper insurance company for payment purposes.

Signature: _____ Date: _____

Subscribed and sworn before me this _____ day of _____, _____.

Notary Public: _____ _____ County _____ State

Seal Expires: _____

RECOMMENDATION FORM
BMH-GT TEEN VOLUNTEER PROGRAM

Teen Applicant's Name: _____

How long have you known the applicant? _____

In what capacity have you known the applicant? (Student, employee, friend, customer, church, etc.)

Please complete the checklist below:

	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE	NO BASIS FOR JUDGEMENT
Maturity				
Creativity				
Communication				
Leadership				
Personality				
Initiative				
Dependability				
Cooperation				
Poise				
Self-discipline				
Ability				
Work with Others				

Briefly describe the applicant's abilities that would make him/her a good candidate for the Teen Volunteer Program.

_____

_____

_____

_____

Comments:

_____

_____

_____

_____ _____

Name Date

_____ _____

Title Organization

Return application by mail, fax or email to: Cathy Johnson, BMH-GT Volunteer Services
P. O. Box 1307~ Columbus, MS 39703-1307
Email: cathy.johnson@bmhcc.org

RECOMMENDATION FORM
BMH-GT TEEN VOLUNTEER PROGRAM

Teen Applicant's Name: _____

How long have you known the applicant? _____

In what capacity have you known the applicant? (Student, employee, friend, customer, church, etc.)

Please complete the checklist below:

	BELOW AVERAGE	AVERAGE	ABOVE AVERAGE	NO BASIS FOR JUDGEMENT
Maturity				
Creativity				
Communication				
Leadership				
Personality				
Initiative				
Dependability				
Cooperation				
Poise				
Self-discipline				
Ability				
Work with Others				

Briefly describe the applicant's abilities that would make him/her a good candidate for the Teen Volunteer Program.

_____

_____

_____

_____

Comments: _____

_____

_____

_____

_____ _____

Name Date

_____ _____

Title Organization

Return application by mail, fax or email to: Cathy Johnson, BMH-GT Volunteer Services
P. O. Box 1307~ Columbus, MS 39703-1307
Email: cathy.johnson@bmhcc.org