Junior Volunteering offers a great chance for you to get some hands-on experience in the career of your choice. We ask for a student’s commitment to at least 50 hours of service to allow an opportunity for career awareness in a hospital setting.

Acceptance of a student for volunteer service at Winchester Medical Center will depend upon the student’s ability to meet the requirements of the Volunteer Services Program. After acceptance, volunteer assignments are made according to interest, availability, and ability to fulfill requirements and designated hours.

Volunteering starts in June depending on the local school schedules.

In order to be considered for the Junior Volunteer Program, please complete the following steps:

- Complete the eighth grade
- Mail or hand deliver completed application to Volunteer Services, Winchester Medical Center, P. O. Box 3340, Winchester VA 22601. Application also available at valleyhealthlink.com
- Submit a brief essay (150 word minimum)
  - Subject should highlight your personal goals.
  - Careful attention should be given to originality, genuineness, and presentation of theme.
  - Neatness counts.
- Submit a signed Parent Information/Permission Form
- Submit a Parental Consent for Medical/Surgical Care of a Minor Form
- Return a signed TB Skin Test Permission Slip
- Submit proof of MMR vaccinations
- Submit two personal reference forms with your name at the top. Reference forms from the following list:
  - One to your school guidance counselor or an instructor
  - One to your Pastor, Sunday School Teacher, Music or Choir Director, Scout Leader, Coach or Neighbor
- The volunteer office will contact you in May to schedule a personal interview.
- Complete training early June.
- Applications will be accepted February 14th through May 1st
WINCHESTER MEDICAL CENTER
2017 JUNIOR VOLUNTEER APPLICATION

Name: ____________________________________________________________
      (Last)     (First)     (Middle)

Home Address: _____________________________________________________
     (Street)     (City)     (State)     (Zip)

Home Phone: ____________________ Age: ______ Birthdate: ____________________

E-mail address ____________________________________________________

School: ___________________________ Grade Completed: _____________

Grade Average: _________ Any Previous Volunteer Experience: ______________

Please describe _____________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

Adult to contact in case of emergency: ________________________________

Home Phone: ____________________ Work Phone: ________________________

Cell Phone: _________________________

Relationship: ________________________________

____________________________________________________________________

Signature of Applicant) ____________________ (Date)

Application due May 1, 2017 – Completed Packets
WINCHESTER MEDICAL CENTER
JUNIOR VOLUNTEER
PARENT INFORMATION/PERMISSION FORM

This will authorize ______________________________, a minor; to participate in junior volunteer activities at Winchester Medical Center from time to time as may be prescribed by the Medical Center’s Director of Volunteer Services or a designated representative. I understand that my daughter or son’s services are donated to the Hospital without contemplation of compensation or future employment, and given for humanitarian, religious or charitable reasons. I also understand that these activities MAY involve observation, not participation, in such areas as the Emergency Room, the Respiratory Therapy Department, etc. to give the junior volunteer a well-balanced experience of hospital work.

We release the hospital and its employees from any claim of liability for damages, injury, and illness resulting to said minor, not occasioned by any fault or neglect on the part of the hospital, while participating in such volunteer activities.

__________________________________________       ________________
(Signature of parent/guardian)                                    (Date)

Parent/Guardian: ______________________________________________

Address: _____________________________________________________

(Street)        (City)        (State)        (Zip)

Place of Employment: __________________________________________

Business Telephone: ___________________           ____________________

(Father)       (Mother)

Home Telephone: ___________________ Cell Phone __________________
I HEREBY AUTHORIZE Winchester Medical Center to care for my child, __________________________________________, at any time while he/she is a junior volunteer at Winchester Medical Center and to arrange for routine or emergency medical/surgical/dental care, vaccinations, and testing as may be required by Winchester Medical Center. I agree that my insurance will be billed for any emergency care that is required for my child, and I (we) will be responsible for any charges not covered by our insurance.

GENERAL INFORMATION

Child’s Name: _______________________________________________
Address: ________________________________________________________________
Telephone: _____________________________________________________________
Insurance Carrier: ________________________________________________________
Group Number: __________________________________________________________
Date of Tetanus: ___________________________Booster: ______________________
Agreement Number: _________________Medicines child is taking:_______________

MEDICAL INFORMATION

Family Physician: __________________________________________________________
Pediatrician: ____________________________________________________________
Surgeon: ________________________________________________________________
Orthopedist: _____________________________________________________________
Allergies: _______________________________________________________________
Child’s Birth Date: _______________________________________________________

In case of emergency, I can be reached at:______________________________

Signature: ___________________________ Date: ___________________________
TO: EMPLOYEE HEALTH NURSE

FROM: DORIS TRANT
DIRECTOR, VOLUNTEER SERVICES

The following individual has agreed to serve the Winchester Medical Center in a Junior Volunteer capacity and will need to be scheduled for the required TB Skin Test:

NAME: _______________________________________

ADDRESS: _____________________________________

____________________________________

Parental Consent for Minors:

____________________________________ has our consent
(Name of Junior Volunteer)

to receive a TB Skin Test.

____________________________________  __________
Signature of Parent or Guardian            Date
WINCHESTER MEDICAL CENTER
JUNIOR VOLUNTEER HEALTH SCREENING

Confidential

Name: ______________________________ Phone #: __________________

Age: _______ Birth date: __________________

Physician: ________________________________

Physician’s Address: ________________________________

PHYSICAL QUESTIONNAIRE

Have you had a TB Test? Yes ____ No ____
If yes, date: ______________ Were you informed of any reaction? Yes ____ No ____

Have you been tested for Acquired Immune Deficiency Syndrome (AIDS)?
Yes_____ No _____ Were you informed of any reaction? Yes ____ No ____

Have you had any surgeries/operations in the past year? Yes____ No ____

Are you currently receiving medical treatment for any illness? Yes ____ No ____
If yes, please explain:

MEDICATIONS AND/OR TREATMENTS ____________________________________________

_________________________________________

ALLERGIES (Please List): ________________________________________________

_________________________________________

FOOD _________________________________________________________________

_________________________________________

OTHER ________________________________________________________________

_________________________________________
**IMMUNIZATIONS** (Check yes or no and state year given)

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<th>No</th>
<th>Year</th>
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<td>Tetanus Booster</td>
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<td>MMR</td>
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<td>Rubeola</td>
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<td>BCG TB Test</td>
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<td>Hepatitis Vaccine</td>
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**PROFILE**

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<tr>
<th>Condition</th>
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<th>No</th>
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<tbody>
<tr>
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<tr>
<td>Mumps</td>
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<tr>
<td>Measles (Red)</td>
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<tr>
<td>Rubella (German or 3 Day)</td>
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<tr>
<td>Scarlet Fever</td>
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<tr>
<td>Asthma</td>
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<td>Hay fever</td>
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<td>Emphysema</td>
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<td>Anemia</td>
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<td>Sickle Cell Anemia</td>
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<tr>
<td>Hepatitis</td>
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<tr>
<td>Tuberculosis</td>
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<tr>
<td>Exposure to Tuberculosis</td>
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<tr>
<td>High Blood Pressure</td>
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<tr>
<td>Cancer</td>
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<tr>
<td>Diabetes</td>
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<tr>
<td>Epilepsy</td>
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<tr>
<td>Rheumatic Fever</td>
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<tr>
<td>Kidney Disease</td>
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<td>Heart Disease</td>
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<td>Thyroid Problem</td>
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Date of last Physical: ________________________________
Personal reference for: ______________________________________

(NAME)

The above student has made application to the Winchester Medical Center Junior Volunteer Program. The primary purpose of this program is to expose students to the health care field and the hospital environment in general and to encourage interest in health careers.

*RATING SYSTEM* – Please indicate by number and circle choice.

1 – Unsatisfactory      2 – Satisfactory      3 – Good      4 – Outstanding

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<td>Attitude</td>
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<tr>
<td>Ability to work well with others</td>
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Please explain any ratings that are unsatisfactory ________________

______________________________________________________________________

Other comments ______________________________________________________________________

Name and Professional/Personal relationship to applicant

__________________________________________________________________________________

Daytime Telephone Number ________________________________

Refer any comments or questions to:

Doris Trant
Director, Volunteer Services
P. O. Box 3340
Winchester, VA 22604

Phone (540) 536-8158
Fax (540) 536-7869
WINCHESTER MEDICAL CENTER
JUNIOR VOLUNTEER SERVICES

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