TEEN VOLUNTEER APPLICATION FORM

OFFICE USE ONLY
Sent Orientation Notice:_____
Orientation Date:_____
Interview Date:_____
Time:_____

Required with your application:

1. **All IMMUNIZATION RECORDS.**
2. **A copy of your last REPORT CARD from school.**
3. **A copy of your BIRTH CERTIFICATE.**
4. **Form must be completed by the Teen Applicant.**

Applicant completes this form. The parent must sign the consent form. Once completed, email, fax or mail your application to the address on the cover page.

NAME	PHONE	CELL Phone
ADDRESS	CITY	STATE / ZIP
E-MAIL	BIRTH DATE	AGE
SCHOOL	GRADE	HOURS REQUIRED FOR SCHOOL
IF EMPLOYED NAME OF EMPLOYER	EMPLOYER PHONE	

Please describe any previous volunteer experience you have:

List any special skills, interests, hobbies that would be and asset in your volunteer services, i.e.: language, clerical, art, music, etc.

Check appropriate box(s). This is the minimum requirement to enter the program.

☐ **6 month Commitment** ☐ **Summer Commitment** Begins the week after school ends, thru the last week before school begins

List three choices of days and hours you are available to volunteer (number your choices in order of preference):

	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
MORNING							
AFTERNOON							
EVENING							

REFERENCE: (an adult, not related to you, that you know through school, community, religious institution, employment)

NAME	PHONE	How do you know this person?
NAME	PHONE	How do you know this person?
EMERGENCY CONTACT	PHONE	RELATION
PHYSICIAN	PHONE	
APPLICANT SIGNATURE		DATE

Miami Children's Hospital Teen Volunteer

PARENTAL CONSENT

I hereby consent to the participation of my daughter/son, in the Teenage Volunteer Program for Miami Children's Hospital.

I also authorize the emergency treatment of my daughter/son (named above) if s/he is injured or taken ill while volunteering for Miami Children's Hospital, if the hospital is unable to contact a parent or guardian for permission to treat.

I also give permission to use any photographs that are taken of my daughter/son, while s/he is volunteering for the hospital, for the use of publicity in promoting the hospital without limitation or reservation.

Signature of
Parent or Guardian: _____ Date: _____

Day Phone: _____ Evening Phone: _____

PARENTAL CONSENT FORM FOR LABORATORY BLOOD TEST

This is a consent for Laboratory Blood Test to test for Tuberculosis exposure, immunities to Rubella, Measles IGG (Rubeola) and Varicella Zoster (Chicken Pox).

I hereby give my permission for my daughter/son: _____

to have **Laboratory Blood Test** done. I understand that there is no charge for this service.

Print Name of Parent or Guardian: _____

Signature of Parent
or Guardian: _____ Date: _____

YOUR PARENT OR GUARDIAN MUST SIGN BOTH PARTS OF THIS CONSENT FORM.