UFHealth
FLAGLER HOSPITAL AUXILIARY

400 Health Park Blvd.
Volunteer Services, Suite 1010
St. Augustine, FL 32086
904.819.4411

Date: _____

PLEASE PRINT

APPLICATION FOR JUNIOR VOLUNTEER
2025 PROGRAM

Please read carefully, print clearly and answer all questions. Submit application to above address or beverly.wolfe@UFHealth.org

PERSONAL/CONTACT INFORMATION:

Name: _____
Last First MI

Street Address: _____ Apt. #_____

City: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

E-Mail: _____

Sex: _____ Male _____ Female Birthdate: ____ - ____ - ____ (min. age 15 by 6/15)
M D Y

IN CASE OF EMERGENCY, NOTIFY:

Parent/Legal Guardian: _____ Relationship: _____

Street Address (if different from above): _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Business Phone: _____ Cell Phone:_____

Email Address: _____

Physician's Name: _____ Phone: _____

SCHEDULE PREFERENCES:

Work Shift:	Mornings	Afternoons	Flexible
Work Day:	Monday	Tuesday	Wednesday
	Thursday	Friday	Flexible

Why do you want to volunteer at UF Health Flagler Hospital?

_____

_____

EDUCATION INFORMATION

School Attending: _____ Grade Level Fall 2025: _____

Guidance Counselor: _____ Phone: _____

SKILLS, ACTIVITIES, AND WORK EXPERIENCE:

Special Skills and Talents:

_____

_____

School Activities and Awards: _____

_____

Community Affiliations: _____

_____

Volunteer Experience: _____

_____

Languages: _____

Do you currently hold CPR certification? Yes_____ No_____

SHIRT SIZE

Ladies	**S**	**M**	**L**	**XL**
Mens	**S**	**M**	**L**	**XL**

MEDICAL HISTORY and AUTHORIZATION **DATE:** _____

As a potential UF Health Flagler Hospital Junior Volunteer you will be required to complete a 2-step Tuberculosis (TB) skin test *prior* to being placed into a volunteer position. The 2 test steps are conducted 1 week apart. If you have a positive reaction to a TB skin test, you will be screened by our Employee Health nurse and given instructions if a follow up is necessary. The hospital will provide the TB skin test **free of charge at UF Health Flagler Hospital** during regularly scheduled clinic hours, or you may have the testing done privately. **This test MUST be completed with results submitted to the Volunteer Office NO LATER THAN JUNE 1ST.**

VOLUNTEER NAME: _____ **AGE**: _____

MEDICAL HISTORY

List Any Restrictions of Applicant: _____

Last Tetanus/Toxoid Booster: _____

Last Flu Shot_____

Last COVID Vaccination_____

Allergies to Drugs/Food: _____

Pertinent Medical History and any Special Medications Taken: _____

_____

TO PARENT:

If your child has epilepsy, diabetes, allergies, heart condition, etc., and/or is taking special medication for any condition, it is important that you advise us so that in the event of an emergency resulting from his/her illness, medical personnel can provide proper treatment. This information will at all times remain confidential, except where it affects his/her ability to receive medical attention.

List any Physical Limitations of Child: _____

_____

AUTHORIZATION

I, we, the undersigned, parent(s)/legal guardian of _____, a minor, in any emergency situation, do hereby authorize Employee Health Nurse or Designee as agents for the undersigned to consent to any UF Health Flagler Hospital: (1) pre-volunteer testing required, 2-step Tuberculosis (TB) skin test (2) x-ray examination; (3) anesthetic; (4) medical or surgical diagnosis or treatment and hospital care which is deemed advisably by, and is to be rendered under the general or special supervision of any physician licensed under the provisions of the Medicine Practice Act on the medical staff of the above named hospital, when such diagnosis or treatment is rendered at said hospital.

It is understood that this authorization is given in advance of any specific diagnosis or hospital care being required and is given to provide authority and power on the part of our aforesaid agent(s) to give specific consent to any and all such diagnosis, treatment of hospital care which the aforementioned physicians, in the exercise of his/her best judgment, may deem advisable in any emergency situation.

It is understood that the effort shall be made to contact the undersigned prior to rendering treatment to the patient, and that any of the above treatment will not be withheld if the undersigned cannot be reached.

SIGNATURE OF PARENT/LEGAL GUARDIAN: _____

Relationship to Student: _____

STUDENT VOLUNTEER CONTRACT

IF ACCEPTED INTO THE UF HEALTH FLAGLER HOSPITAL JUNIOR VOLUNTEER PROGRAM, I AGREE TO:

- **Commit to participate the entire four (4) week period: June 13 until July 18, 2025. No Junior Volunteers will be scheduled to work June 30 – July 4, 2025.**
- Attend ***MANDATORY*** Orientation and in-service training scheduled for **Friday, June 13, 2025.**
- I understand and am able to fulfill the requirement to work a minimum of 4 hours a week.
- I will hold all information as confidential concerning patients, families, staff members, physicians and volunteers.
- Become familiar with UF Health Flagler Hospital policies and procedures and uphold the Code of Conduct.
- Be punctual to my assigned area.
- Honor my commitment to a specific job assignment.
- Donate my services without expectation of compensation or future employment.
- I will make my service professional in all ways. I will conduct myself with dignity, courtesy, and have consideration for others.
- Purchase the appropriate volunteer uniform and maintain a well-groomed appearance.
- Carry out assignments in a professional manner and seek Auxiliary assistance when necessary.
- Discuss any problems, criticism or suggestions with the Volunteer Services Specialist.
- Adhere to the UF Health Flagler Hospital Auxiliary sign-in procedure.
- I understand that the following may result in immediate dismissal: breach of confidentiality; lack of honesty; failure to complete work; personal attacks; not showing up to work as scheduled.
- I will not make or receive personal phone calls (land line or cellular) while on duty unless it is for emergency purposes. This includes text messages.
- I understand that only patients are to be seated and/or transported in the hospital wheelchairs.
- I understand that I must comply with the dress code as presented in pre-program interviews.

Student Signature_____

Date_____

PARENT/GUARDIAN AGREEMENT

- **My child must commit to participate for the entire four (4) week program, from June 13 until July 18, 2025. No Junior Volunteers will be scheduled to work June 30 – July 4, 2025.**
- My child must attend ***MANDATORY*** orientation and in-service training scheduled for **Friday, June 13, 2025, 9:30 – 11:30 a.m**.
- My child must purchase a uniform shirt for $20 to be paid at the orientation.
- If my child is taking the CPR Training course, payment of $10 must be made at the orientation.
- My child must work in the assigned area. Assignments cannot be changed without the express permission of the Volunteer Services Department.
- I understand that **Volunteer Services Department** reserves the right to terminate my child's status as a result of (a) failure to comply with UF Health Flagler Hospital policies; (b) absences without prior notification; (c) unsatisfactory attitude, work or appearance, or (d) any other circumstances which, in the judgment of the department director, would make continued services as a volunteer contrary to the best interests of UF Health Flagler Hospital and its patients.
- I give my consent for my son/daughter to submit this application to join the UF Health Flagler Hospital Junior Volunteer Program.
- I give consent for UF Health Flagler Hospital to administer to my child a 2-step Tuberculosis (TB) skin test. The 2 test steps must be conducted 1 week apart. **This testing MUST be completed with results submitted to the Volunteer Office NO LATER THAN JUNE 1ST.**

SIGNATURES:

_____

Parent/Guardian Signature

STUDENT'S NAME:_____

TEACHER RECOMMENDATION:

I recommend _____ to serve as a UF Health Flagler Hospital Junior Volunteer.

Comments: His/Her grade point average is a 3.0. or higher:

_____

_____

_____

_____

Teachers Signature: _____

Date: _____

School: _____

Phone: _____

ADULT RECOMMENDATION:

I recommend _____ to serve as a UF Health Flagler Hospital Junior Volunteer.

Comments: _____

_____

_____

_____

_____

Reference Signature: _____

Date: _____

Reference Phone #:_____