

Dear Prospective Teen Volunteer:

Thank you for your interest in Central DuPage Hospital's Teen Volunteer Program! Volunteering is a great way to gain experience and knowledge that will enhance your skills, as well as contribute to the everyday running of our hospital.

The State of Illinois, as well as Hospital policy, govern the rules that apply to your volunteer position. Please read the following information carefully.

AGE: 14-18 years old and in High School

UNIFORM: CDH Volunteer vest. Your contribution to the cost is \$10.00.

HEALTH RECORDS: *REQUIRED* A copy of MMR and Varicella immunizations must be presented at the time of the TB testing.

FORMS: Volunteer Application, Agreement/Pledge Form, Parental Consent Form, Consent for Medical Treatment Form, Teacher Reference Form, Volunteer Responsibility Form

TEEN SCHEDULE:

- School days: maximum of three hours of volunteer service
- Weekends: maximum of eight hours of volunteer service per day

When you have completed the application forms, please return them to the CDH Volunteer Office. You may mail or fax them to the Volunteer Office, fax number 630-933-5278. Upon receipt of the completed application, we will contact you to set up an interview to discuss your specific information. Appointments for interviews are made between the hours of 10:00 a.m. and 4:00 p.m., Monday through Friday.

I look forward to meeting you and welcoming you as a Teen Volunteer.

Best regards,

Laurel McDonnell Volunteer Services Manager



Central DuPage Hospital

TEEN VOLUNTEER APPLICATION

(Please Print)

Ms. / Mr.		
Last	First	Middle
Home Add	ress City	Zip
Home Pho	one Cell Phone	E-Mail Address
School	Year	Birth Date
1	EMERGENCY CONTACT INFOR	RMATION
	G U D	W. L.DI
Father's Name	Cell Phone	Work Phone
Mother's Name	Cell Phone	Work Phone
Alternate Adult	Home Phone	Cell Phone
		
	EXPERIENCE & INTERES	STS
VOLUNTEER EXPERIENCE:		
WORK EXPERIENCE:		
HOBBIES, SPECIAL INTEREST	TS:	
SCHOOL ACTIVITIES:		
ARE YOU EMPLOYED? [] Ye	es [] No IF YES, WHERE?	
Briefly explain why you	wish to volunteer at Cadence Health	:



TEEN APPLICATION AGREEMENT AND PLEDGE

Central DuPage Hospital

I realize that without my full support the Volunteer Services Department of Central DuPage Hospital will not be able to fulfill its purposes of providing volunteer services in the hospital and promoting health and welfare in the community. I therefore agree to the following:

- I will be punctual and conscientious in the fulfillment of my duties and accept supervision graciously.
- I will conduct myself with dignity, courtesy, consideration, and maturity. I will observe the CDH uniform code.
- I will take any problems, criticisms, or suggestions to the Director or Manager of Volunteer Services.
- I will consider all information which I may hear directly or indirectly concerning a patient, doctor, or any member of the hospital personnel as confidential. I will not seek information regarding a patient except as it pertains to my volunteer assignment.
- I will uphold the traditions and standards of Central DuPage Hospital and abide by all Central DuPage Hospital confidential and security policies and procedures and adhere to the Behavior Standards.
- I will uphold the traditions and standards of Central DuPage Hospital and will safeguard its reputation while maintaining the highest standards of confidentiality.
- I promise to observe hospital ethics, regulations, and endeavor to make my work of the highest quality.
- I will notify the volunteer office if I am unable to be present for my shift. I understand that three misses without an excused absence will result in termination from the volunteer program.

Date

I have read the above Hospital Teen Volunteer Agreement and Pledge and understand the
importance of maintaining confidentiality in my work as a volunteer at Central DuPage
Hospital.

Teen Volunteer Signature



TEEN PARENT/GUARDIAN CONSENT FORM

Central DuPage Hospital

My (our) daughter/son,		has my (our) consent to
serve as a teen volunteer at Central	DuPage Hospital.	
I understand that the decision to vo son/daughter in his/her volunteer co experience as an opportunity to lear experience and realize that students their volunteer schedules, appointment notification will result in dismissal	ommitment. I will encourage hirn and grow. I will facilitate my are strongly encouraged to be plents, and commitments. Repear	im/her to use this volunteer y son's/daughter's volunteer personally responsible for ited absences without
I (we) have read the application agricommitment.	reement and will share in the res	sponsibility of this
I (we) also give my (our) consent for testing.	or my (our) daughter/son to rece	eive necessary TB (Mantoux)
I (we) understand that should my cl volunteering, that I (we) will be res My son/daughter is not covered und plans.	ponsible for the cost of related	medical care and treatment.
I understand that my child will rece orientation and/or interview.	eive a copy of the attached response	onsibility form at the time of
PLEASE CALL EMPLOYEE HEA CONCERNS. PLEASE NOTE TH IMMUNIZATIONS MUST BE PR	IAT A COPY OF TEEN'S MM	R AND VARICELLA
Parent/Guardian Signature	Parent/Guardian Signature	Date



TEEN VOLUNTEER CONSENT FOR TREATMENT CENTRAL DU PAGE HOSPITAL

Family's Last Name:			
Child's First Name	Middle Initial	Date of Birth	Allergies or Special Information
Parent/Guardian Name(s):			Home Phone:
Street Address:			Cell Phone:
City, State, Zip:			Work Phone:
Relative/Friend to contact:			Phone Number:
Family Physician:			Phone Number:
	cost of related m	edical care and tr	al attention while he/she is volunteering, that reatment. My son/daughter is not covered as.
Parent	Guardian Signat	ure	Date

INSTRUCTIONS

Cadence Health feels that it is very important to begin treatment on injuries or diseases as soon as possible. In the event your child is brought to our emergency department and we are unable to contact you, this form will help us begin treatment and diagnostic testing. The emergency staff will still attempt to contact you to get personal permission to treat.

Read the entire form and complete all areas. Place your family's last name at the top of the consent form. Relative/Friend should be someone you feel could give us more information about your child or tell us how to get in contact with you. If you require more room to write Allergies or Special Information, please use the back of this form.



COUNSELOR/TEACHER REFERENCE CENTRAL DU PAGE HOSPITAL TEEN VOLUNTEER PROGRAM

has recently applied to be a Teen Volunteer at
Central DuPage Hospital. A Teen Volunteer needs a reference from a teacher or counselor
(someone other than a relative). We would appreciate you taking the time to answer the
following questions. The information will be treated in the strictest confidence. If you have any
questions regarding the information requested, please contact the Volunteer Office at 630-933-
2252.
We welcome students and are concerned that their schoolwork not suffer as a result of
volunteering. Do you think that the applicant's schoolwork will be adversely affected if she/he
volunteers during non-school hours? Please comment.
Would you recommend the applicant as dependable, qualified, responsible, and with respect and
strong moral character for the position of a Teen Volunteer? Please comment.
strong moral character for the position of a reen voluneer. Thease comment
How long have you known the applicant?
In what capacity have you known the applicant?
Additional comments:
Tidditional comments.
Counselor/Teacher Signature Date Phone Number
Please return to: Central DuPage Hospital

Volunteer Services Department 25 North Winfield Road Winfield, IL 6019



Volunteer Responsibilities:

- Proper Uniform: \$10.00 fee for teens. Uniform must be worn at all times including initial training.
- No fragrances
- Closed toe shoes
- Professional Appearance: This includes black, khaki, or navy slacks or skirt; white or off white shirt and volunteer vest or smock for hospital based volunteers.
- You must notify the office if you are unable to present for your service.

Delnor Volunteers: 630/208-4264
 CDH Volunteers: 630/933-2252
 CDH Gift Shop Volunteers: 630/933-2253

- Off campus volunteers please refer to your supervisor
- If appropriate please arrange for a substitute.
- All medical requirements must be completed prior to your initial training. This includes proof of MMR and Varicella as well as completed TB testing.
- Volunteer office staff must be notified of any unusual incidents that occur while you are volunteering. If you are unable to reach us please call:
- Delnor: Nursing supervisor 83083.
- CDH: Nursing supervisor 31449
- In the case of an emergency always call 44444 immediately.
- Should you require medical attention please know that you are <u>not</u> covered under the hospital's medical insurance or worker's compensation programs. Your parents (if you are under 18) or you will be responsible for medical costs associated with any care or treatment that is required.
- Should you have any questions about any of our volunteer procedures please call:

Central Du Page: 630/933-2252Delnor: 630/208-4264