



# CAMP INDEPENDENCE WINTER 2019



## Volunteer Application

(All volunteers must be at least 16 years old)

### Personal Information

Please print using black or blue ink.

Circle one: Mr./Ms./Mrs./Dr.

Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_

First Name: \_\_\_\_\_ MI \_\_\_\_\_

### Current Address

### Permanent address (if different from current)

Street: \_\_\_\_\_

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_

E-Mail Address: \_\_\_\_\_

High School

College

Graduate School

Adult

In case of an emergency, notify: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

*Volunteers under age 18 must list a parent or legal guardian as emergency contact.*

### Educational History

High School or Program: \_\_\_\_\_ Present Grade: \_\_\_\_\_

High School Completed:  Yes  No

College: \_\_\_\_\_ Major: \_\_\_\_\_  Undergraduate  Graduate

Anticipated Graduation Date: \_\_\_\_\_

BS/BA

MS/MA

DPT/OTD/Ph.D.

Other \_\_\_\_\_

### Employment

Present (or most recent) Employer

Company Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Phone number: \_\_\_\_\_ Fax number: \_\_\_\_\_

Position: \_\_\_\_\_ Dates of Employment: \_\_\_\_\_

Have you ever been employed by St. Louis Children's Hospital?  no  yes (If yes, please specify)

Department: \_\_\_\_\_ Manager/Supervisor: \_\_\_\_\_

Dates of employment (MM/YY): from \_\_\_\_\_ to \_\_\_\_\_

(over)

## **Volunteer Information**

I am applying for 2019 Winter Camp Independence: **(Bring warm clothes for ice-skating each day)**

Monday, December 30, 2019     Tuesday, December 31, 2019

School Service Coordinator: \_\_\_\_\_ Day time phone #: \_\_\_\_\_

Do you prefer to volunteer (check one) in the:

All Day (Preferred)       Morning (9:00 – 12:00)       Afternoon (1:00 – 4:00)

I would like to volunteer for the Hatfield Cerebral Sports & Rehabilitation Center at St. Louis Children's Hospital because: \_\_\_\_\_  
\_\_\_\_\_

If you could create for yourself the perfect volunteer experience, what would it be? \_\_\_\_\_  
\_\_\_\_\_

How did you hear about us?     Internet       Newspaper       Employee       Other: \_\_\_\_\_

## **References**

It is mandatory that all applicants provide two references that are current and professional in nature. All applicants must have two references-unless you have volunteered in the past. If you have never volunteered with the CP Sports program, fill out the reference below and complete the volunteer reference forms.

Enclosed are two reference forms. Please fill in your name and give them to two people you wish to use as a reference. References can not be a relative, or individual with whom you reside, and must be 19 years or older. High School students should use at least one teacher, counselor or coach as a reference. Please ask your references to complete the form and return it to us promptly.

For our records, please complete the section below. Please provide complete addresses.

### **Reference One:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Business/School Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

### **Reference Two:**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Business/School Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

## **Immunization History**

**Immunization Record:** Students (High School and College) **MUST** provide a copy of immunization records from a health care provider. Please include these records with your application.

<b>Have you ever had:</b>	<b>Unknown</b>	<b>No</b>	<b>Yes</b>	<b>Date</b>	<b>Immunization/Date</b>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> _____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> _____
Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> _____
Mumps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> _____
Rubella	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> _____
Polio	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> _____

**FLU SHOT (MUST HAVE TO VOLUNTEER AT WINTER CAMP)**  \_\_\_\_\_

**Tuberculosis Skin Test Guidelines:** All new volunteers are required to have a TB test within the last 12 months.

- If you have had a TB test in the past 12 months, enclose a copy of the test results.
- If you have not had a TB test in the past 12 months, a test can be done free of charge at the hospital.

By signing this application, I agree to the following:

- I release from all liability or responsibility all persons or organizations requesting or supplying information regarding my character and qualifications.
- I understand that I may come in contact with information that is confidential in nature.
- I understand the sensitive nature of health care information and I agree to protect the privacy and confidentiality of patients and families.
- I will provide complete reference information, documentation of immunizations, flu shot and TB test results.
- I have provided information, which is true and complete to the best of my knowledge.
- If I have provided false information, I may not be allowed to volunteer or I may be dismissed in the future.
- I understand that any misuse of information is grounds for termination of my volunteer service without prior notice.

**Signature of Applicant:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**For applicants under 18 years of age:**

**Parental/Guardian Permission (required for applicants under 18 years of age).**

**I give my child \_\_\_\_\_ permission to volunteer at St. Louis Children's Hospital and I agree to the following statements,**

- I understand that my child may obtain a record of hours volunteered.
- I will provide a copy of the test results if my child has had a tuberculosis skin test within the last year.
- I give permission for my child to receive a TB test at St. Louis Children's Hospital if a record can not be produced.
- I understand that my child is required to have a TB test before he/she can begin volunteering.
- As long as my child is a volunteer at St. Louis Children's Hospital, I agree that my child may have annual TB testing performed by the Hospital.

**Signature of Parent or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Please review the Volunteer Application carefully before submitting it. Any missing or incomplete information can delay processing of your application.

**Contact Information:**

St. Louis Children's Hospital  
 Hatfield Cerebral Palsy Sports and Rehabilitation Center  
 One Children's Place, Therapy Services 4E2  
**mary.eckhard@bjc.org**  
 St. Louis, MO 63110  
 Phone: (314) 454-2642 Fax: (314) 454-6035



# ID Badge Form/Background Check

Please print.

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Date of Birth (MM/DD/YY) \_\_\_\_\_ Sex: \_\_\_\_\_ Social Security No. \_\_\_\_\_

The above information is required for all volunteers.

Volunteers age 18 and over - A background check is required on all applicants over 18 years of age. To do a background check, we must have your permanent address and your prior addresses from the past five years.

### Permanent Address

Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

### Address for the Past Five Years

Street: \_\_\_\_\_ Street: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Other than minor traffic offenses in which the fine imposed was \$100 or less, have you ever:

- Been convicted of a crime (misdemeanor or felony)?
- Received a probated sentence (including deferred adjudication) for an alleged crime?
- Been assigned a probation officer?
- Plead guilty, no contest, or nolo contendere to an alleged crime?
- Been made the subject of a complaint or investigation concerning alleged child or elder abuse or neglect?
- Been listed on the employee disqualification list maintained by the Missouri Division of Social Services, or any other state?

No  Yes If the answer is **YES**, specify the offense, date, place, and court which has a record thereof.

By signing this form, I agree to the following:

- I authorize the release of any criminal history records and information to St. Louis Children's Hospital.
- I understand that my volunteer assignment is contingent upon a clean background check.
- I understand that St. Louis Children's Hospital will conduct a child abuse screening on me through the Division of Family Services and a criminal background check.
- I release from all liability or responsibility all persons or organizations requesting or supplying information regarding my character and qualifications.
- I have provided information, which is true and complete to the best of my knowledge.
- If I have provided false information, I may not be allowed to volunteer or I may be dismissed in the future.

Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

### For office use only:

OIG  One Screen

Date Started: \_\_\_\_\_

DFS  EDL  \_\_\_\_\_

Date Completed: \_\_\_\_\_

# CAMP INDEPENDENCE

## St. Louis Children's Hospital Volunteer Reference



Please complete the following information and return it to:  
 St. Louis Children's Hospital  
 Hatfield Cerebral Palsy & Sports Rehabilitation Center  
 One Children's Place, Room 4S50  
 St. Louis, MO 63110  
 (314) 454-2642

Applicant's Name:	_____
Address:	_____
City, State, ZIP:	_____
Phone Number:	_____

\_\_\_\_\_ has applied to volunteer at St. Louis Children's Hospital. Your reference is important in helping us decide whether to accept this applicant as a volunteer. Please take a few minutes to tell us how you perceive the candidate in each of the following categories and return the form to the above address at your earliest convenience. Thank you for your help.

Please indicate with a checkmark below the candidate's ability to:

Category	Excellent	Very Good	Average	Fair	Poor	N/A
Work with children						
Fulfill commitments and responsibilities						
Maintain confidentiality						
Exhibit emotional maturity						
Communicate verbally						
Take initiative						
Be courteous and polite to others						
Work as a member of a team						
Accept redirection or constructive criticism						
Follow instructions						
Work independently						
Perform tasks						
Understand and adhere to organizational structure, policies and procedures						
Manage stressful situations						
Be flexible/adaptable to change						
Be prompt						

Comments (may continue on back) \_\_\_\_\_

How long have you known the applicant? \_\_\_\_\_

How do you know the applicant? \_\_\_\_\_

Name (please print) \_\_\_\_\_

Signature \_\_\_\_\_

Daytime Phone Number ( ) \_\_\_\_\_ Date \_\_\_\_\_

**CAMP INDEPENDENCE**



**St. Louis Children's Hospital  
Volunteer Reference**

Please complete the following information and return it to:  
 St. Louis Children's Hospital  
 Hatfield Cerebral Palsy Sports & Rehabilitation Center  
 One Children's Place, Room 4S50  
 St. Louis, MO 63110  
 (314) 454-2642

Applicant's Name:	_____
Address:	_____
City, State, ZIP:	_____
Phone Number:	_____

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Be flexible/adaptable to change						
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Comments (may continue on back) \_\_\_\_\_

How long have you known the applicant? \_\_\_\_\_

How do you know the applicant? \_\_\_\_\_

Name (please print) \_\_\_\_\_

Signature \_\_\_\_\_

Daytime Phone Number ( ) \_\_\_\_\_ Date \_\_\_\_\_

## Volunteer Application Checklist

Please use this checklist to ensure your application is complete.

**Please print, using either black or blue ink.**

Please do not use pencil.

**List Emergency contact.**

Are you under the age of 18? If yes, you must list a parent or legal guardian as your emergency contact. Please list their first and last name, relationship and phone.

**Fill out the reference section completely.**

All applicants must have two references-unless you have volunteered in the past. If you have never volunteered with the CP Sports program, the completed reference forms can either be submitted with your application, or your reference can mail the completed form separately. We will begin to process your application when both references are received.

Give the forms to the two people you listed on the application. The completed form must be returned. Applicants can not use a parent, other relative, or individual with whom you reside as a reference.

**Complete the immunization section, get a TB Test and Flu Shot.**

High School and College Students must provide a copy of immunization records, TB Test and Flu Shot from a health care provider with their application. Please do not have your health care provider fax it separately. Adults should provide the dates of the immunization or the disease itself. You can get the TB Test and Flu shot in the Occupation Health Department at St. Louis Children's Hospital if needed free of charge.

**Sign and date the application.**

If you are under 18 years of age, your parent or guardian must also sign and date the application.

**Complete the ID Badge Form/Background Check page.**

All applicants regardless of age must complete the top portion of the application. Our Security Department requires this information in order to provide a Volunteer ID Badge. Applicants over the age of 18 must complete the entire form. If you are a college student, please use your home address as your permanent address.

**Mail your application!**

Please mail to the Contact Information address at the bottom of page 3.

Questions? Call us at 314-454-2642 or e-mail [mary.eckhard@bjc.org](mailto:mary.eckhard@bjc.org).