Baptist Health-Fort Smith
Caring Teen Program
Checklist

(Make sure you have all the documents below before handing in your application packet.)

<u>Do not print any document on both sides of a sheet of paper.</u>

____Letter To Parents signed

____COVID-19 vaccination card

Or
____ COVID Declination

____Criteria Form signed

____Application

____Essay – 400 to 500 typed words, check your spelling, and count your words because I will.

____If Accepted I Agree Form

____Recommendation Form – Must be Baptist Health-Fort Smith recommendation forms, not letters of recommendations. **<u>2 recommendation forms required</u>**

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____Grades

____School or state ID (If available)

____Shot Records - Required

____Health Information Form

____Tobacco & Drug Testing Policy

____Gym Permission Slip Form

____Authority to interview/photo Form

Baptist Health
FORT SMITH

Application deadline is 3/29/2024, nothing will be accepted after the deadline date.

Counselor/Teacher Recommendation Form **Do not give back to the students!**

Dear Counselor/Teacher:

_____has applied to the Caring Teen Program. Thank you for taking your valuable time to complete this evaluation. Your observations are an important part of this student's application. Would you please comment on this student's record in the following areas?

Personal Qualities

Attitude towards school	___Excellent	___Good	___ Fair	___ Poor
Cooperation	___Always Cooperates	___Cooperates	___Sometimes cooperates	___Poor
Emotional Maturity	___Very mature	___Age appropriate	___Sometimes mature	___very immature
Integrity	___Highly trustworthy	___Trustworthy	___Usually trustworthy	___ Questionable
Follow Rules by supervisor or Administration	___Always follows rules	___Mostly follows rules	___ Sometimes follows rules	___Never follows rules
Leadership potential	___Leader	___Can follow or lead	___Leads on occasion	___Rarely leads
Reaction to criticism	___Excellent	___Good	___Fair	___Poor
Responsible	___Very responsible	___Usually responsible	___Sometimes responsible	___Rarely
Self-confidence	___Healthy self-image	___Needs some support	___Seems overconfident	___Poor self-image
Self-control	___Excellent	___Good	___Fair	___Poor
Warmth of personality	___Always friendly	___Usually friendly	___Occasional friendly	___Rarely friendly
Ability to work independently	___Consistently works well	___Needs help occasionally	___Needs help frequently	___Needs help

Work Skills

Class participation	___Joins in readily	___Contributes some	___Wants to dominate	___Rarely contributes
Ability to work in group	___Always works well	___Sometimes	___Has difficulty	___Has great difficulty
Ability to work independently	___Always works well	___Needs some help	___Needs help frequently	___Needs constant help
Completes assignments	___Consistently	___Usually completes	___Needs additional time	___Has difficulty completing
Follows directions	___Easily and	___Needs some help	___Needs	___Rarely
Takes initiative	___Always	___Usually	___Sometimes	___Rarely
Attention span	___Actively engaged	___Attentive	___Variable attention	___Requires frequent redirection

.

Social Skills

Peer relations	___Role model	___Healthy relationship	___Occasional problems	___Relates poorly
Relationship with adults	___Courteous	___Usually Positive	___Occasional problems	___Shows little respect
Concern for others	___Very considerate	___Considerate	___Usually considerate	___rarely considerate
Attitude towards school	___Excellent	___Good	___Fair	___Poor

Classroom conduct: **Please comment on the student's behavior/attitude**:

Areas of greatest strength and greatest weakness/need:

Would you recommend this student for the Caring Teen School Program? ___Yes or ___No **Application deadline is 3/29/2024**

Evaluator's name **(please print)**: _____Phone no. _____

Evaluator's Signature: _____Date: _____Title/School: _____

Please either fax to my office at 479-441-4005 or mail to Baptist Health-Fort Smith Volunteer Office 1001 Towson Ave. Fort Smith, AR 72902 **If you are mailing please allow 7 days for delivery.** **DO NOT GIVE BACK TO THE STUDENT**

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FORT SMITH

Thank you for your interest in the **2024 Caring Teen Summer Volunteer** program at Baptist Health-Fort Smith Hospital.

Due to the responsibilities encountered by Baptist Health volunteers, we have an extensive screening process.

Criteria:

- 14 to 17 years old
- Must be available Tuesdays & Thursdays
- We expect our Caring Teens to take their volunteer assignments seriously, just as they would their class attendance or employment. If you are unable to meet the required time commitment, we ask that you not apply.
- Not all teens who receive application packets will be accepted into the program.

Application Requirements:

- Have your COVID-19 vaccination card or sign a COVID-19 Declination Vaccine Form
- Essay on topic provided 400 - 500 typed words. Make sure you have counted your words. **I will not email/call you and tell you that you do not have 400-500 words. You will be disqualified.**
- All forms must have parent and teens signatures, **no electronic signatures, they are not legal.**
- No school email addresses, some emails did not get through our computer firewall and and applications were not received.

- A meeting on April 11th at 6:00 p.m. to 7:00 p.m. for one parent and teen. The mandatory meeting is in the Baptist Health Classroom on the first floor of the hospital.
- Once accepted into the program, we will have pictures made for our badges on May 20th at 3:30 pm or May 22nd at 2:30 pm. We will meet in my office and walk over to Human Resources.
- It is mandatory to attend the Caring Teen Hospital Orientation, June 4, 2024.

The application must be completed by your child, if it is completed by anyone other than the person applying for the program, they will be disqualified from the program.

Do not submit your application until you have all of the documents requirements. Use the checklist that is provided to make sure all documents are attached.

Applicants will receive a phone call/email confirmation - once ALL requirements are met. Most communication is done by phone/email. Please provide the teens phone number and email address so that we can have the opportunity to assess the teen's readiness for a volunteer position at our hospital, it is important that communication be handled by the teen directly.

Application MUST be turned into Baptist-Health-Fort Smith by March 29th **no later than 4:30 pm**. No applications will be accepted after that date.

I recommend you call and make sure your application and your recommendation forms have arrived. Give yourself enough time in case a recommendation forms has not arrived.

If you are mailing the application packet, please allow at least 7 days for delivery. If it is delivered past the deadline it will not be counted. Do not email your application packet from a school email address, our firewalls will not always let your email in and I will not receive your application. Do not send a zip file, Baptist Health IT department does not accept that type of file.

If you email the application from your home email address, call and verify that I have received it.

You can hand deliver, fax, email or mail the completed Caring Teen application packet to:

Baptist Health-Fort Smith
Amanda Collins
Volunteer Services & Programs Officer
Volunteer Services
1001 Towson Avenue
Fort Smith, AR 72902-2406
Phone 479-441-5555 amanda.collins@baptist-health.org
Fax: 479-441-4005

_____ _____

Parents signature - I have read the above information Date
No electronic signatures

_____ _____

Teen's signature - I have read the above information Date
No electronic signatures

Caring Teen Essay

Topic

Why you are interested in participating in the Caring Teen Program and what you hope to learn from it.

400 – 500 TYPED words
I will count your words

Day Pass _____ Week Pass_____ Inpatient Family Pass_____ Teen Volunteer Summer Pass_____

Please Print

Marvin Altman Fitness Center
Visitor Consent Form
PLEASE PRINT!!!!!

Visitor Name_____

Address _____

City/State/Zip_____

Telephone ( ) _____ Date of Birth_____

Today's date_____ E-Mail _____

Emergency Contact _____
Name Phone no

Medical Questionnaire

Please read the following questions and answer each by placing a check mark in either the "Yes" or "No" box.

1. Has your physician stated you have heart trouble? Yes _____ No_____
2. Do you frequently have pains in your heart or chest? Yes _____ No_____
3. Do you often feel faint or have serve dizziness? Yes _____ No_____
4. Has a physician stated you have high blood pressure? Yes _____ No _____
   a. If yes, is it currently being treated? Yes _____ No _____
   b. If yes, is it being controlled by a physician? Yes _____ No _____
5. Are you currently pregnant? Yes _____ No _____

Health Promotion Program

I, _____, acknowledge that I am a participant at the Marvin Altman Fitness Center.

I have answered the Medical Questionnaire listed above to the best of my ability and knowledge. I realize my admission to the program and beneficial results depends on the accuracy of my answers.

I understand that I will be undergoing physical activities for the purpose of enhancing my emotional, mental and physical well being. Although the activities are designed to minimized injury, I understand that I could be injured by physical contact, strain, or sprain, resulting in damage to bones, joint, ligaments or muscles. I also understand that I could sustain damage to my heart or respiratory system, which could result in injury or death.

Should any such injury, damage or death occur, I will not hold Marvin Altman Fitness Center or Baptist Health-Fort Smith responsible or liable.

I also understand that Marvin Altman Fitness Center and Baptist Health-Fort Smith are not responsible for lost or stolen property. With such understanding, I consent to participate at Marvin Altman Fitness Center.

Volunteen's Signature_____
No electronic signatures

Parent or Guardian Signature_____
No electronic signatures

Staff Signature _____

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Health Information

PLEASE PRINT

Physician's Name_____ Phone Number _____

Address_____

Health Limitations_____

Allergic to _____

Are you in good health? ____Yes ____No Are you taking medications? ____Yes ____No

If yes, list _____

Do you have medical problems? ___Yes ___No

If yes, list _____

Have you ever had a tuberculosis skin test? ___Yes ___No In the last 12 months? ___Yes ___No

If yes, please provide documentation.

I certify that the above information is true and complete to the best of my knowledge. I realize this information is confidential and may be used to determine my eligibility to volunteer. I authorize Baptist Health-Fort Smith to make inquiry to my physician regarding the state of my health.

_____
Volunteer Signature
No electronic signatures

_____
Parent/Guardian Signature
No electronic signatures

_____
Date

Baptist Health
FORT SMITH

If Accepted As A Baptist Health Caring Teen Volunteer, I Agree That:

1. I will use confidential information, only as needed to perform my volunteer duties. I will not access confidential information without legitimate need/permission, nor in any way divulge, copy, release, sell, lend, revise, alter, or destroy any confidential information belonging to Baptist Health-Fort Smith Hospital. I understand that I will be automatically dismissed as a volunteer if I do not respect my responsibility for maintaining confidentiality.

2. My services are donated to the hospital and given for humanitarian, religious, or charitable reasons.

3. I understand that it is a crime to solicit business for attorneys. I shall not solicit any business for attorneys or insurance companies, both on or off of hospital property, or act as a runner or a capper for an attorney in the solicitation business. I shall report all known occurrences of solicitation for attorneys to the Volunteer Services & Program Officer.

4. I shall not sell or attempt to sell goods or services, request contributions or solicit persons to sign or distribute political petition on hospital premises unless I receive the express authorization of the Volunteer Services & Programs Officer to engage in these activities.

5. I understand that I am required to provide my COVID-19 vaccination card or sign a COVID-19 Vaccine Declination Form. I must have a flu (when in season, October 1st – March 31st) as a condition of my acceptance into the volunteer program.

6. Shot records are required and must be up to date.

7. I must be clean and neat at all times, daily baths are required.

3. I shall attempt to resolve any problems related to my volunteer assignment with my unit/department supervisor, if unsuccessful I will attempt to resolve any such problems with the Volunteer Services & Programs Officer.

5. I shall make my best effort to fulfill my commitment to the hospital by completing all assignments that I accept.

10. I shall at all times uphold the mission of the hospital.

11. I understand that the Volunteer Services Department reserves the right to terminate my volunteer status as a result of :

Failure to comply with hospital policies, rules, and regulations which includes horse play in the hospital.

Breach of HIPAA or confidentiality standards.

Taking pictures and posting on ANY internet site.

Three absences without prior notification.

Unsatisfactory attitude, work or appearance.

Caught using cell phone during volunteer hours, other then lunch or break.

Being under the influence of alcohol or drugs.

Bring a weapon on the campus.

If a reasonable suspicion, drug test is administered and failure of the test.

Any other circumstances which, in the judgment of the Volunteer Services & Programs Officer or Directors, which would make my continued services as volunteer to the contrary best interest of the hospital.

This is not a full list of all reason for dismissal.

I have read all of the above conditions and I agree to adhere to them.

_____

Volunteer Signature
No electronic signatures

_____

Parent/Guardian Signature
No electronic signatures

Date _____

March 1, 2024

Dear Parents:

Thank you for allowing your child to be involved in the Caring Teen program here at Baptist Health-Fort Smith.

We believe the program is very beneficial for the students. Not only do they learn responsibility for devoting their time and energy to the program, but they can take a deep look into the medical field and see how many different departments it takes to make a hospital run.

Every step of this program is a learning process, from filling out the application, following instructions and interviewing.

With the amount of teens that apply for our program, not everyone will receive the volunteer assignment they are most interested in; again there are many different departments that make this hospital function as a team.

Not only is this a commitment for your child, it is also an eight-week commitment for you as parents. You are committing to have your child at Baptist Health-Fort Smith every Tuesday and Thursday from 9:00 a.m. to 4:00 p.m. We do provide lunch for your child.

We expect our Caring Teens to take their volunteer assignments seriously, just as they would their class attendance or employment. If either one of you are unable to meet the required time commitment, we ask that they not apply. If your child is going to be gone for any prolong period of time during this program, they may want to reconsider being in the program until they can devote more time to it.

There will be a **mandatory** meeting for one parent and teen on Thursday, April 11th starting at 6:00 p.m. and will run until 7:00 p.m. The meeting is in the Baptist Health Classroom on the first floor of the hospital. **If you and your child do not attend this meeting it will disqualify your child from the program.**

Hospital Orientation is mandatory; if your child can not make the Orientation which is June 4th they cannot participate in the Caring Teen Program.

Please remind your child that our primary mode of communication is through their phone and email. So please remind them to have **their voicemail set up**, to check their phone and email messages frequently.

Tobacco & Drug Testing Policy

I understand that Baptist Health-Fort Smith has a Tobacco Policy that does not allow their employees to smoke and that there is no smoking allowed on all Baptist Health-Fort Smith properties. I understand as a Auxilian/volunteer/volunteen, I am not allowed to smoke while I am volunteering. I understand that my clothes can not smell like smoke; if I smell like smoke I will be requested to go home and change.

Volunteen Signature_____ Date_____

No electronic signatures

Parents Signature_____ Date_____

No electronic signatures

If there is any reasonable suspicion, testing known as for cause drug testing will be performed. If supervisors have evidence or reasonable cause to suspect an Auxilians/volunteers/volunteens of drug use the Auxilians/volunteers/volunteens who are suspected of drug use or a policy violation are generally advised not return to work while awaiting their tests results. Generally, if an Auxilian/volunteer/volunteen is suspected of being drunk on the premises, a urine alcohol test will be administered and the Auxilian/volunteer/volunteen will be send home.

Reasonable suspicion

Auxilians/volunteers/volunteens are subject to testing based on (but not limited to) observations by at least two members of management of apparent workplace use, possession or impairment. HR, the Volunteer Services & Programs Officer or the Clinical Quality Executive should be consulted before sending the Auxilian/volunteer/volunteen for testing. The Reasonable Suspicion Observation Checklist may be used to document specific observations and behaviors that create a reasonable suspicion that an Auxilian/volunteer/volunteen is under the influence of illegal drugs or alcohol. Examples includes but not limited to:

- Odors (smell of alcohol, body odor).
- Movements (unsteady, fidgety, dizzy).
- Eyes (dilated, constricted or watery eyes, or involuntary eye movements).
- Face (flushed, sweating, confused or blank look).
- Speech (slurred, slow, distracted mid-thought, inability to verbalize thoughts).
- Emotions (argumentative, agitated, irritable, drowsy).
- Actions (yawning, twitching).
- Inactions (sleeping, unconscious, no reaction to questions).

I understand that if we have to test your child for any of the above, parents will be notified.

Volunteen Signature_____ Date _____

No electronic signatures

Parents Signature_____ Date _____

No electronic signatures

Baptist Health
FORT SMITH

Authority to Interview / Photograph

Name _____

Please Print

Address _____ Phone _____

City/State/Zip_____

I hereby give consent to an interview/photograph by representatives of Baptist Health-Fort Smith (or other entity specified below) and release the hospital from any situation that may result from its use. I release any ownership to the audio, video, or photographs, and allow the hospital (or other entity specified below) to use these as needed.

This interview/photograph will be used for _____

Date _____

Signature of Teen _____

No electronic signatures

Signature of Parent _____

No electronic signatures

COVID-19 VACCINE DECLINATION

Employee Name _____ EE ID # _____

WHY VACCINATE?
COVID-19 (coronavirus disease 2019) is a disease caused by a virus named SARS-CoV-2. It can be very contagious and spreads quickly.COVID-19 most often causes respiratory symptoms that can feel much like a cold, the flu, or pneumonia. COVID-19 spreads when an infected person breathes out droplets and very small particles that contain the virus.Anyone infected with COVID-19 can spread it, even if they do NOT have symptoms.

THE VACCINE
Vaccine recommendations are based on age, time since last dose, and in some cases, the first vaccine received. Pfizer-BioNTech COVID-19 vaccine is a mRNA vaccine. Everyone 6 years and older should get 1 updated Pfizer-BioNTech COVID-19 vaccine, regardless of whether they've received any original COVID-19 vaccines. People aged 65 years and older may get 1 additional dose of COVID-19 vaccine 4 or more months after the 1st updated COVID-19 vaccine. People who are moderately or severely immunocompromised may get 1 additional dose of updated COVID-19 vaccine 2 or more months after the last updated COVID-19 vaccine.

EXCEPTIONS
If in the past you have had a severe allergic reaction to an ingredient in an COVID-19 vaccine or if you have a known allergy to an ingredient in a COVID-19 vaccine, you should not get that COVID-19 vaccine.

WHAT TO EXPECT AFTER THE SHOT
Side effects after getting a COVID-19 vaccine can vary from person to person. Side effects after a COVID-19 vaccination tend to be mild, temporary, and like those experienced after routine vaccinations. For adults 18 years or older, side effects can include redness and swelling on the arm where the shot was administered and tiredness, headache, muscle pain, chills, fever, and nausea throughout the rest of the body.

I HAVE READ THE ABOVE INFORMATION, HAVE HAD AN OPPORTUNITY TO ASK QUESTIONS. I DECLINE THE VACCINE AT THIS TIME. I UNDERSTAND I CONTINUE TO BE AT RISK OF ACQUIRING COVID-19. IF IN THE FUTURE, I CHANGE MY MIND AND WANT TO BE VACCINATED I CAN REQUEST AND RECEIVE IT. ☐ **DECLINE**

I DECLINE THE VACCINE BECAUSE I HAVE ALREADY HAD THIS VACCINE.
☐ **DECLINE**

_____ **Date**

_____ **Volunteer Signature**

_____ **Parent Signature**

_____ **Volunteer Staff Signature**