

Baptist Health-Fort Smith  
Caring Teen Program  
Checklist

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

**Do not print any document on both sides of a sheet of paper.**

\_\_\_ 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. **2 recommendation forms required**

\_\_\_ Recommendation Form – Must be Baptist Health-Fort Smith recommendation forms, not letters of recommendations. **2 recommendation forms required**

\_\_\_ 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



Deadline date to return  
to office is  
**3/29/2024**  
by **4:30 p.m.**

**Caring Teen Program**  
**June 4, 2024 - July 25, 2024**  
**1001 Towson Avenue**  
**P.O. Box 2406**  
**Fort Smith, AR 72902-2406**

\_\_\_\_\_ New Volunteer

\_\_\_\_\_ Returning Volunteer

\_\_\_\_\_ Polo Size

**A \$20 charge for all Polo's**

**NO APPLICATIONS WILL  
BE ACCEPTED AFTER  
THAT DATE.**

**Office Use Only**

**Date Received:**

\_\_\_\_\_  
**Received By:**

**PLEASE PRINT**

Name: \_\_\_\_\_ Telephone : \_\_\_\_\_

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

**(No school email addresses)**

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Social Security: \_\_\_\_\_

Parents Contact Information:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Emergency Contact:

Name: \_\_\_\_\_ Telephone: \_\_\_\_\_

Prior Volunteer Experience: \_\_\_\_\_

Why do you want to volunteer at Baptist Health? \_\_\_\_\_

Are you related to or do you know an employee of Baptist Health – Fort Smith Hospital?  yes  no

If so, what is their name? \_\_\_\_\_ Relationship \_\_\_\_\_

Department: \_\_\_\_\_ Contact Number: \_\_\_\_\_

I understand that my child can not volunteer in the same area as any family members or close friends.

Special talents, hobbies or interests: \_\_\_\_\_

What other activities will you be involved with this summer? Will these interfere with volunteering here?

Cell Phones are **ONLY** allowed on lunch and break times. **If caught using cell phone during any other time, you will be terminated.**

**Have you ever been convicted, or pleaded “no contest” to a felony and/or misdemeanor?**  
\_\_\_\_\_ No \_\_\_\_\_ Yes

The **Caring Teen Summer Program** is a eight week program. **All applicants must commit** to a regular weekly schedule of Tuesdays and Thursdays and must complete a **minimum of 98 hours**. With school practices and vacations, we require the student to have complete 98 hours before they end of the summer program.

**I understand that if I am planning any prolonged period of time away during the 8 week program, this is not a program I should consider at this time.**

If I am accepted as a Baptist Health-Fort Smith Caring Teen Volunteer, I understand that I am making a eight week commitment to volunteer during the summer.

My child has permission to ride to and from Baptist Health-Fort Smith Hospital with \_\_\_\_\_

\_\_\_\_\_  
Date

\_\_\_\_\_  
Volunteer Signature- **Application must be completed by teenager**  
**No electronic signatures**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Signature  
**No electronic signatures**

Comments: \_\_\_\_\_



## 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**

**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	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Cooperation	<input type="checkbox"/> Always Cooperates	<input type="checkbox"/> Cooperates	<input type="checkbox"/> Sometimes cooperates	<input type="checkbox"/> Poor
<b>Emotional Maturity</b>	<input type="checkbox"/> Very mature	<input type="checkbox"/> Age appropriate	<input type="checkbox"/> Sometimes mature	<input type="checkbox"/> very immature
<b>Integrity</b>	<input type="checkbox"/> Highly trustworthy	<input type="checkbox"/> Trustworthy	<input type="checkbox"/> Usually trustworthy	<input type="checkbox"/> Questionable
<b>Follow Rules by supervisor or</b>				
<b>Administration</b>	<input type="checkbox"/> Always follows rules	<input type="checkbox"/> Mostly follows rules	<input type="checkbox"/> Sometimes follows rules	<input type="checkbox"/> Never follows rules
Leadership potential	<input type="checkbox"/> Leader	<input type="checkbox"/> Can follow or lead	<input type="checkbox"/> Leads on occasion	<input type="checkbox"/> Rarely leads
<b>Reaction to criticism</b>	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
<b>Responsible</b>	<input type="checkbox"/> Very responsible	<input type="checkbox"/> Usually responsible	<input type="checkbox"/> Sometimes responsible	<input type="checkbox"/> Rarely
<b>Self-confidence</b>	<input type="checkbox"/> Healthy self-image	<input type="checkbox"/> Needs some support	<input type="checkbox"/> Seems overconfident	<input type="checkbox"/> Poor self-image
Self-control	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor
Warmth of personality	<input type="checkbox"/> Always friendly	<input type="checkbox"/> Usually friendly	<input type="checkbox"/> Occasional friendly	<input type="checkbox"/> Rarely friendly
<b>Ability to work independently</b>	<input type="checkbox"/> Consistently works well	<input type="checkbox"/> Needs help occasionally	<input type="checkbox"/> Needs help frequently	<input type="checkbox"/> Needs help

**Work Skills**

Class participation	<input type="checkbox"/> Joins in readily	<input type="checkbox"/> Contributes some	<input type="checkbox"/> Wants to dominate	<input type="checkbox"/> Rarely contributes
Ability to work in group	<input type="checkbox"/> Always works well	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Has difficulty	<input type="checkbox"/> Has great difficulty
Ability to work independently	<input type="checkbox"/> Always works well	<input type="checkbox"/> Needs some help	<input type="checkbox"/> Needs help frequently	<input type="checkbox"/> Needs constant help
Completes assignments	<input type="checkbox"/> Consistently	<input type="checkbox"/> Usually completes	<input type="checkbox"/> Needs additional time	<input type="checkbox"/> Has difficulty completing
<b>Follows directions</b>	<input type="checkbox"/> Easily and	<input type="checkbox"/> Needs some help	<input type="checkbox"/> Needs	<input type="checkbox"/> Rarely
Takes initiative	<input type="checkbox"/> Always	<input type="checkbox"/> Usually	<input type="checkbox"/> Sometimes	<input type="checkbox"/> Rarely
Attention span	<input type="checkbox"/> Actively engaged	<input type="checkbox"/> Attentive	<input type="checkbox"/> Variable attention	<input type="checkbox"/> Requires frequent redirection

**Social Skills**

Peer relations	<input type="checkbox"/> Role model	<input type="checkbox"/> Healthy relationship	<input type="checkbox"/> Occasional problems	<input type="checkbox"/> Relates poorly
Relationship with adults	<input type="checkbox"/> Courteous	<input type="checkbox"/> Usually Positive	<input type="checkbox"/> Occasional problems	<input type="checkbox"/> Shows little respect
<b>Concern for others</b>	<input type="checkbox"/> Very considerate	<input type="checkbox"/> Considerate	<input type="checkbox"/> Usually considerate	<input type="checkbox"/> rarely considerate
Attitude towards school	<input type="checkbox"/> Excellent	<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> 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****

Baptist Health-Fort Smith  
Caring Teen Program  
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## **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**

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 11<sup>th</sup> 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 4<sup>th</sup> 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.

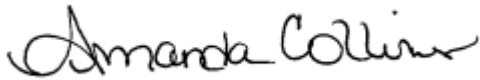


The application must be completed by your child, if it is completed by anyone other than the person applying for the program, they will be disqualified from the program.

If you have any questions, please give me a call at 479-441-5555.

Thank you for standing with your child in this program.

Sincerely,

A handwritten signature in cursive script that reads "Amanda Collins".

Amanda Collins  
Volunteer Services & Programs Officer

---

Students Signature  
**No electronic signatures**

---

Parents Signature  
**No electronic signatures**

## 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**

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 applications were not received.
- A meeting on April 11<sup>th</sup> 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 20<sup>th</sup> at 3:30 pm or May 22<sup>nd</sup> 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 29<sup>th</sup> **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  
**No electronic signatures**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Teen's signature - I have read the above information  
**No electronic signatures**

\_\_\_\_\_  
Date

Day Pass \_\_\_\_\_ Week Pass \_\_\_\_\_ Inpatient Family Pass \_\_\_\_\_ Teen Volunteer Summer Pass \_\_\_\_\_

**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 \_\_\_\_\_

## Health Information

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

## **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 1<sup>st</sup> – March 31<sup>st</sup>) 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 than 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 \_\_\_\_\_



## **Tobacco and 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**

# **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

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

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- Once accepted into the program, we will have pictures made for our badges on May 20<sup>th</sup> at 3:30 pm or May 22<sup>nd</sup> 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 29<sup>th</sup> **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  
**No electronic signatures**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Teen's signature - I have read the above information  
**No electronic signatures**

\_\_\_\_\_  
Date



## 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**

**Marvin Altman Fitness Center**

**Visitor Consent Form**

**PLEASE PRINT!!!!**

**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 \_\_\_\_\_



# Baptist Health

## FORT SMITH

### 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

**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 1<sup>st</sup> – March 31<sup>st</sup>) 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 11<sup>th</sup> 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 4<sup>th</sup> they cannot participate in the Caring Teen Program.

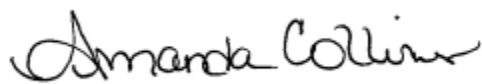
Please remind your child that our primary mode of communication is through their phone and email. So please remind them to have **their voicemail set up**, to check their phone and email messages frequently.

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.

If you have any questions, please give me a call at 479-441-5555.

Thank you for standing with your child in this program.

Sincerely,

A handwritten signature in black ink that reads "Amanda Collins". The signature is written in a cursive style with a large initial 'A'.

Amanda Collins  
Volunteer Services & Programs Officer

---

Students Signature  
**No electronic signatures**

---

Parents Signature  
**No electronic signatures**

## 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**