Student Volunteen Application

Northern Montana Hospital

Name _____
Last *First* *Middle* *Nickname*

Address _____ City/Zip _____ Telephone _____

Age _____ Date of Birth _____ Current Grade _____ Graduation Year _____

Parents/Guardians _____

IN EMERGENCY NOTIFY

Name _____ Relationship _____

Telephone *Home* ( ) _____ *Work* ( ) _____

Employer _____ City/Zip _____

Volunteer Experience _____ Career Plans _____

School Activities _____

Other Activites _____ Hobbies _____

Do you have a part time job? _____ Employer _____ Days _____ Hours _____

How did you learn about our program? _____

Areas of interest _____ Personal preferences _____

Time available	M	TU	W	TH	F	S	SU
Morning	___	___	___	___	___	___	___
Afternoon	___	___	___	___	___	___	___
Evening	___	___	___	___	___	___	___

For Office Use Only:
Orientation Date _____ Termination Date _____
Reg/Hours Card _____ Reason _____
Sign In Sheet _____ Schedule Given _____
Name Tag _____ TB Test _____

CONSENT FOR MINOR TO PARTICIPATE IN VOLUNTEER ACTIVITES

This will authorize _____, a minor, to participate in such volunteer activities at Northern Montana Hospital as may from time to time be required by the Hospital's Volunteer Services Manager, or the designated representative. We release Northern Montana Hospital from any claim to liability for any injury or illness resulting to said minor, not occasioned by any fault of neglect on the part of the Hospital, while participating in such volunteer activities.

_____ _____
Signature Parents/Guardians

_____
Date

Health Questionnaire

Physician_____

Address_____

City_____ Zip_____ Telephone_____

1. Have you had any serious illness or operation? _____Yes _____No
   Describe_____

   _____

2. Date of last physical examination and results_____

   _____

3. Have you been immunized for:

   Poliomeylitis _____Yes _____No Date of Booster_____

   Smallpox _____Yes _____No Date of Booster_____

   Tetanus _____Yes _____No Date of Booster_____

   Rubella _____Yes _____No Date of Booster_____

4. Have you ever had, or do you now have any of the following?

   a. Chronic or frequent colds or cough? _____Yes _____No
   b. Dizziness or fainting spells? _____Yes _____No
   c. Shortness of breath? _____Yes _____No
   d. Pain in chest/palpitations? _____Yes _____No
   e. Seizures? _____Yes _____No
   f. Tuberculosis? _____Yes _____No
   h. Skin infections, rashes or boils? _____Yes _____No
   i. Back aches or back surgery? _____Yes _____No
   j. Arthritis? _____Yes _____No
   k. Hay fever, asthma or allergies? _____Yes _____No
   l. High blood pressure? _____Yes _____No
   m. Drug or medication reactions? _____Yes _____No
   n. Are you presently taking any medication daily? _____Yes _____No

I hereby certify that the above 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 work in patient areas. I authorize Northern Montana Hospital to make inquiries to my physician, regarding the state of my health.

CONSENT TO IMMUNIZATIONS, TESTS & X-RAYS AS REQUIRED

I agree to submit to examinations which may include appropriate immunizations, which may be necessary as part of my volunteer service. I hereby authorize my doctor(s) to furnish Northern Montana Hospital, information concerning my health. I also authorize the person(s) making tests or x-ray films to report the results to the hospital.

_____ _____

Signature Parents/Guardians

_____

Date