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## REGINA HOSPITAL

Thank you for your interest in **Regina Hospital's Youth Volunteer Program**.

Volunteering is a good way to make new friends and experience the personal gratification of having served your community.

Here is the process of getting ready to share your time and energy with us.

- Enrollment – Please complete the attached enrollment paperwork. I hope that we can offer you an area of service that is compatible with your interests and availability. Regina Hospital is required to perform a background check, so please thoroughly review the application and complete the attached forms.
  - A parent or guardian must complete the consent section.
  - The recommendation section needs to be completed by a school counselor, teacher, coach, youth group leader or other adult non-family member who has worked with you in a supervisory capacity.
- Getting Started - The Volunteer Office will contact you after reviewing your application to discuss next steps and schedule an orientation session.
- Health – Prospective volunteers must verify immunity to measles, mumps, rubella, chicken pox, and tuberculosis. If you are not sure about some of your vaccinations, a blood test may be required to verify immunizations at no cost to you. Additionally, if any vaccines are needed, they may also be offered to you at no cost.
- General Orientation – We will schedule a time for you to attend a general orientation session to learn what you need to know about Regina Hospital before you get started.

I look forward to meeting with you and pursuing your interest in volunteering at Regina Hospital – Part of Allina Health. Please feel free to contact me if you have any questions.

Sincerely,

**Maria Reis**

Volunteer Services Coordinator

651.404.1104

Email: [maria.reis@allina.com](mailto:maria.reis@allina.com)



# REGINA HOSPITAL

## YOUTH VOLUNTEER SERVICES ENROLLMENT FORM (Age 13-17)

Name \_\_\_\_\_ Birth date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Phone 1 \_\_\_\_\_ Phone 2 \_\_\_\_\_  
 Email address: \_\_\_\_\_  
 Driver's License #: \_\_\_\_\_ State \_\_\_\_\_

### GENERAL INFORMATION

School presently attending \_\_\_\_\_  
 Grade \_\_\_\_\_ Graduation year \_\_\_\_\_  
 Are you performing this volunteer service because it is required? YES NO (circle one)  
 If YES: 1) Reason hours are needed \_\_\_\_\_  
 2) Number of hours required \_\_\_\_\_  
 3) Completion deadline \_\_\_\_\_  
 How would you arrange transportation? \_\_\_\_\_  
 When are you available \_\_\_\_\_

### AREA(S) OF INTEREST

Please indicate general area(s) that may interest you, keeping in mind that your choices may change as you discover more about us.

\_\_\_\_\_ Patient experience cart (age 13-17) – pass out items (cards/crossword puzzles, Sudoku) to patients in the Medical Surgical department  
 \_\_\_\_\_ Orthopedic and sports therapy unit helper (age 14-17) light office duties, runs errands, replaces linens/checks supplies  
 \_\_\_\_\_ Escort (age 14-17) assists in registration area (no Saturday or Sunday)  
 \_\_\_\_\_ Other \_\_\_\_\_

### SIGNATURES

The information provided in this enrollment form is true. I understand that if this information is false in any way, I will be dismissed without notice regardless of when the false information is discovered. I realize that if accepted as a volunteer, I must abide by the rules, regulations and expectations of the Volunteer Department and Regina Hospital.

Youth signature \_\_\_\_\_ Date \_\_\_\_\_  
 Parent/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Return application to:  
 Regina Hospital Volunteer Services  
 Attn: Maria Reis  
 1175 Nininger Road  
 Hastings, MN 55033

Questions?  
 Call Volunteer Services at 651.404.1104



# REGINA HOSPITAL

## YOUTH VOLUNTEER PARENTAL CONSENT FORM

In order for your child to become a volunteer with us, we need your consent and your involvement in helping them have a productive experience. Please read and sign this parental consent form if you would like us to consider your child as a possible volunteer. Feel free to call Volunteer Services at 651.404.1132 if you have any questions, would like further information, or would like to discuss this with someone.

- Your child will receive orientation and training which is necessary for the safe and responsible performance of the duties he or she will be asked to perform.
- Your child will be expected to meet all the requirements of the position, including regular attendance and adherence to policies and procedures.

## VERIFICATION OF IMMUNITY

Medical staff personnel will verify immunity to the following diseases: measles, mumps, rubella, chicken pox, and tuberculosis. If your child's immunization record is unavailable, our medical staff will provide a free test at Allina Health's laboratory to verify immunity. *Parental consent will be required for vaccination only.*

## IN CASE OF INJURY

If your child is injured while performing volunteer services, it is Regina's policy to provide immediate first-aid treatment at the expense of the hospital. Your own insurance company shall be the primary carrier in the case of an injury that requires further treatment.

\_\_\_\_ I give permission for immediate emergency medical treatment. Notify emergency contact person listed below as soon as possible.

\_\_\_\_ I DO NOT give permission for emergency medical treatment until I have been contacted.

## IN AN EMERGENCY PLEASE NOTIFY

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

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone 1: \_\_\_\_\_ Phone 2: \_\_\_\_\_ Phone 3: \_\_\_\_\_

*I understand that my child wishes to be considered for volunteer work and if accepted by Regina Hospital, I hereby give my consent for them to serve in that capacity. I understand that my child will not receive monetary compensation for the services contributed.*

\_\_\_\_\_  
Parent/Guardian signature

\_\_\_\_\_  
Date

Return application to:  
Regina Hospital Volunteer Services  
Attn: Maria Reis  
1175 Nininger Road  
Hastings, MN 55033

Questions?  
Call Volunteer Services at 651.404.1104



# REGINA HOSPITAL

## YOUTH VOLUNTEER RECOMMENDATION FORM

Youth who wish to volunteer at Regina Hospital are required to submit a personal recommendation from a school counselor, teacher, coach, youth group leader or other adult non-family member who has worked with him or her in a supervisory capacity.

\_\_\_\_\_ is interested in volunteering at Regina Hospital.

Volunteer candidate name

Name of person providing this recommendation \_\_\_\_\_

Please print name

How long have you known this youth? \_\_\_\_\_

What is your relationship? \_\_\_\_\_

What three words would you use to describe this youth?

1 \_\_\_\_\_ 2 \_\_\_\_\_ 3 \_\_\_\_\_

Describe how this youth gets along with people in general \_\_\_\_\_

\_\_\_\_\_

Your recommendation \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Phone \_\_\_\_\_ Best time to reach you \_\_\_\_\_

Return form to:  
Regina Hospital Volunteer Services  
Attn: Maria Reis  
1175 Nininger Road  
Hastings, MN 55033

Questions?  
Call Volunteer Services at 651.404.1104

## Background Check Disclosure for Allina Health Volunteers

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Allina Health, including its subsidiary and affiliate corporations, may:

- order a consumer report (a background report) on you in connection with your application to volunteer at Allina Health
- order additional background reports on you for purposes of your volunteer role if you become a volunteer, or if you already volunteer for Allina Health.

The background report may contain information concerning your character, general reputation, personal characteristics, mode of living and criminal history. Information may be obtained from private and public record sources.

The current consumer reporting agencies (CRAs) are:

|  |  |
|--|--|
| Verified Credentials, Inc.<br>20890 Kenbridge Court<br>Lakeville, MN 55044<br>952-985-7200<br>Toll free:1-800-473-4934 | Bureau of Criminal Apprehension<br>BCA Headquarters – St. Paul<br>1430 Maryland Avenue East<br>St. Paul, MN 55106-2802<br>651-793-2400 |
|--|--|

You have the right in most circumstances to submit a written report to the CRAs for a complete and accurate disclosure of the nature and scope of any consumer report Allina Health ordered about you. The CRAs must provide you with this disclosure form within five business days after its receipt of your request or the report was requested by Allina Health, whichever date is later.

## Background Check Authorization for Allina Health Volunteers

By signing below, I authorize Allina Health, including its subsidiary and affiliate corporations, to obtain a consumer report in connection with my application for a volunteer role, or, as allowed by law, at any time during my volunteer role and from a consumer reporting agency (CRA) other than Verified Credentials, Inc.

For the purpose of preparing a background check for Allina Health, and only for that specific purpose, and subject to all laws protecting my information and individual privacy, I also authorize that the following information may be disclosed to the CRA as needed to compile the report: my past and present employers; learning institutions, including colleges and universities; law enforcement and all other federal, state and local agencies; federal, state and local courts; the military; credit bureaus; testing facilities; and motor vehicle records agencies. By signing below, I acknowledge the information that can be disclosed to the CRA, if and only as allowed by law, includes information related to my criminal background, motor vehicle history, employment and earnings history, education, personal references, character, mode of living, credit background, civil judgments or liens, military service, and professional credentials and licenses.

A volunteer opportunity with Allina Health is contingent upon a satisfactory background investigation. If I become a volunteer, I authorize Allina Health to order additional background reports while volunteering with Allina Health related to any of the above issues without asking me for my authorization again.

I may receive a copy of any consumer report obtained by Allina Health at no expense to me. I understand that I may request additional information on the nature of the report upon written request to the CRA. These searches will be conducted by: Verified Credentials, Inc., 20890 Kenbridge Court, Lakeville, MN 55044, 800-473-4934, [www.verifiedcredentials.com](http://www.verifiedcredentials.com). Check this box if you would like a free copy of your background report:  Yes  No

*A copy of this authorization has the same validity as the original.*

| Identity Information and Address History   |                                |                  |
|--|--------------------------------|------------------|
| <b>First Name</b>  | <b>Middle Name</b>             | <b>Last Name</b> |
| <b>Former name(s) or alias you have used in the past</b> (including maiden name):        |                                |                  |
| <b>Date of Birth*</b>  | <b>Social Security Number*</b> |                  |
| <b>Phone</b>   | <b>Email Address</b>           |                  |
| Please list ALL the of the addresses where you have lived during the <b>last 7 years</b> |                                |                  |
| <b>Current:</b>  |                                |                  |
| <b>Previous:</b>   |                                |                  |
| <b>Previous:</b>   |                                |                  |
| <b>Previous:</b>   |                                |                  |
| <b>Signature:</b>  |                                | <b>Date:</b>     |

\* This information is used for identification purposes only

**Regina Hospital and Regina Auxiliary**  
Infectious Disease and Immunization Tracking

Name: \_\_\_\_\_ SSN# \_\_\_\_\_ Date of birth: \_\_\_\_\_

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

Phone Number to reach you at during the day: \_\_\_\_\_

Places you have lived outside USA: \_\_\_\_\_

Work Site: \_\_\_\_\_ Department: \_\_\_\_\_

Manager Name: \_\_\_\_\_

- Submit the completed form and documentation of all vaccinations to Employee Occupational Health (EOH), or call 612-262-4490 for further instruction.

| PLEASE READ THROUGH ALL THE FOLLOWING QUESTIONS.<br>CHECK ALL ANSWERS THAT APPLY TO YOU.  | FOR SUPERVISOR   |
|---|--|
| <p><b>Tuberculosis (TB)</b></p> <p>_____ I have never had a skin test or blood test for TB (Mantoux)</p> <p>_____ I have had a negative skin test for TB</p> <p>_____ Approximate date of last test (month and year) _____</p> <p>_____ I have received BCG vaccine (uncommon in U.S.)</p> <p>_____ I have had a positive skin test or blood test for TB</p> <p>_____ not treated _____ treated with isoniazid (INH) or other medication</p> <p>Dates of treatment: _____ Duration of treatment _____</p> <p>_____ I have or have had TB</p> <p>_____ I have had a reaction (e.g. redness, swelling or bump) to TB skin test. If yes, describe: _____</p> <p><b>Current Health Status – Any current symptoms such as:</b></p> <p>_____ fever _____ cough over 3 weeks _____ bloody sputum _____ night sweats _____ weight loss</p> <p>_____ no current symptoms</p> | <p>2 Step TB skin testing or a QFT for all who have patient contact (within 3 feet of patients). If 2 step TB skin testing - a neg test in previous 12 months is used for 1<sup>st</sup> step.</p> |
| <p><b>Mumps</b></p> <p>_____ I had Mumps. If yes, have documentation that you had it? yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>_____ I have had two Mumps vaccines. If yes, have documentation that you had it yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>_____ I have been tested for Mumps antibody. Date _____</p> <p>Was test: positive <input type="checkbox"/> negative <input type="checkbox"/> don't know <input type="checkbox"/></p> <p>_____ I don't know if I have had Mumps or been vaccinated</p>   |  |
| <p><b>Rubella (German Measles)</b></p> <p>_____ I had German Measles. If yes, have documentation that you had it? yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>_____ I had rubella vaccine. If yes, have documentation that you had it? yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>_____ I have been tested for rubella antibody. Date _____</p> <p>Was test: positive <input type="checkbox"/> negative <input type="checkbox"/> don't know <input type="checkbox"/></p> <p>_____ I don't know if I have had German measles or been vaccinated</p>   |  |
| <p><b>Measles (Rubeola) (Red Measles)</b></p> <p>_____ I had Measles. If yes, have documentation that you had it? yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>_____ I have had Measles vaccine. If yes, have documentation that you had it yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>_____ I have been tested for rubeola antibody. Date _____</p> <p>Was test: positive <input type="checkbox"/> negative <input type="checkbox"/> don't know <input type="checkbox"/></p> <p>_____ I don't know if I have had Measles (Rubeola) or been vaccinated</p>  |  |

**Regina Hospital and Regina Auxiliary**  
**Infectious Disease and Immunization Tracking**

|  |  |
|--|--|
| <p><b>Chickenpox</b></p> <p>_____ I have had chickenpox/and or shingles (also called Herpes Zoster).<br/>         If yes, do you have MD documentation of having the disease?      yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>_____ I have had chickenpox (Varicella) vaccine.<br/>         If yes, do you have documentation of two vaccinations?      yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>_____ I have been tested for chickenpox immunity.<br/>         If yes, do you have documentation of lab titer results?      yes <input type="checkbox"/> no <input type="checkbox"/></p> <p>_____ I don't know if I have had Chickenpox/and or shingles or been vaccinated</p>  |  |
| <p><b>Tetanus / Diphtheria / Pertussis</b></p> <p>_____ I had a primary series of 3 or 4 doses of DT, DPT, Td, or Tetanus vaccine<br/>         _____ Date of last tetanus vaccine "booster"<br/>         _____ Date of last documented DPT vaccine</p> <p>_____ I had a single adult does of Tdap vaccine<br/>         _____ Date of documented Tdap vaccine</p> <p>_____ Allergy</p> <p>_____ Unknown</p>   |  |
| <p><b>Hepatitis B (required only if your assignments have the potential for blood &amp; body fluid exposure)</b></p> <p>_____ I have had Hepatitis B. If yes, date _____.</p> <p>_____ I have had the Hepatitis B vaccine. If yes, approximate dates:<br/>         Dose 1 _____ Dose 2 _____ Dose 3 _____ Dose 4 _____<br/>         Other (describe) _____</p> <p>_____ I have been tested for Hepatitis B antibody. If yes, date _____.<br/>         Where tested _____<br/>         Was test: positive <input type="checkbox"/> negative <input type="checkbox"/> don't know <input type="checkbox"/></p> <p>_____ I have had Hepatitis B surface antigen test. If yes, date _____.<br/>         Was test: positive <input type="checkbox"/> negative <input type="checkbox"/> don't know <input type="checkbox"/></p> <p>_____ I don't know if I have had Hepatitis or been vaccinated.</p> |  |
| <p><b>Immune Status:</b> People with weakened immunity are at risk for more serious disease due to infection and may also pass infection more easily to others. Check if you have had the following:</p> <p>_____ Splenectomy (spleen removed)<br/>         _____ Organ transplant<br/>         _____ Chronic steroid use (taking Cortisone, Prednisone, etc.). If yes:<br/>         Name of medication(s) and dose _____<br/>         _____ How long have you been on these medications? _____</p> <p>_____ Chemotherapy or radiation<br/>         _____ Immune deficiency disease: lymphoma <input type="checkbox"/> leukemia <input type="checkbox"/> HIV infection <input type="checkbox"/><br/>         _____ Other malignancy or condition<br/>         (list) _____</p>   |  |



**Regina Hospital and Regina Auxiliary**  
Infectious Disease and Immunization Tracking

**CONSENT:**

VOLUNTEER NAME (Please Print): \_\_\_\_\_

VOLUNTER SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

By checking this box, I consent for a detailed voicemail to be left in regards to any type of follow up needed.

**PARENTAL CONSENT required if applicant under 18 years old:**

\_\_\_\_\_  
DATE:

(parent/guardian signature)

*By signing above, you are consenting to have your child receive the necessary lab tests and/or immunizations in order to be cleared to work as a volunteer.*

**Please include copies of all prior immunization records and/or lab titers for:**

- TB skin test or QFT (TB blood test)
- Chest x-ray only if positive TB history
- MMR (Measles, Mumps, Rubella)
- Hepatitis B
- Tdap or TD
- Influenza
- Chicken Pox (Varicella)

Choose the lab you would like to go to. Wait 3 days to allow your order to be received and set up. You can report to the lab within 3 to 14 business days after you submit your request.

Blood tests that may be ordered are:

1. Tuberculosis screening (QFT-Quantiferon Gold Test)
2. Immunity assessment to Measles, Mumps, Rubella, and Chicken Pox

**Lab Locations to choose from are:**

- Hastings Allina Health Clinic**  
1880 N. Frontage Road  
Hastings, MN 55033  
**Hours:** Monday-Friday 8am-3:30pm

For Questions: Please contact Heidi Willhite, Occupational Health Tech. **Phone:** 651-241-5481; **Email:** heidi.willhite@allina.com

**OFFICE USE ONLY:**

EOH CLEARANCE SIGNATURE: \_\_\_\_\_ Date: \_\_\_\_\_