VOLUNTEEN APPLICATION

Email Address: ______________________

PLEASE PRINT DATE: ____________

NAME: ______________________
Last First MI Nickname

ADDRESS: ______________________ ( ) -
Street City State Zip Phone

AGE: ____ Date of Birth: ______ School Name: ______ Grade in Fall; Graduation Year: ______

Parents/Guardians: ______________ Daytime Phone: ( ) ______ ( ) ______
Father Mother

IN CASE OF EMERGENCY, NOTIFY:

NAME: ______________________
RELATIONSHIP
: ______________________
PHONE: HOME: ( ) ______
WORK: ( )
COMPANY NAME: ______________
CITY: ______________

CHECK IF YOU HAVE ANY TRAINING OR EXPERIENCE:

Arts & Crafts	____	Lettering	____
Bookkeeping	____	Music	____
Cashiering	____	Paper Route	____
Computers	____	Sales	____
Data Entry	____	Typing	____
Filing	____	Speed ____ wpm	

Previous Volunteer Experience: ______________________
Career Plans: ______________________
School Activities: ______________________
Hobbies and Other Areas of Interest: ______________________
Do you have a part-time job? ____ Company: ______ Days: ______ Hours: ______
How did you become interested in Volunteens? ______________________
Preliminary Assignment Preferences, if know:

1. ______________________
2. ______________________
3. ______________________

INDICATE ALL TIMES & DAYS YOU ARE AVAILABLE

*Write time available & indicate day / time preference with an asterisk**

	M	TU	W	TH	F	S	SU
Morning							
Afternoon							
Evening							

MANDATORY ORIENTATION OR REVIEW
(Check One)

New Volunteen Orientation
___ 6/3/16 1:30 pm– 3:30 pm
___ 6/7/16 10 AM – 12 PM

Experienced Volunteen Review
___ 6/9/16 10 am–11:30 am
___ 6/10/16 1:30 pm – 3 pm

VOLUNTEEN APPLICATION

McDonough District Hospital

REV: 4.21.16 nld **VOL-05** 9503360 EFF: 4.21.16

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REV: 4.21.16 nld **VOL-05** 9503360 EFF: 4.21.16

Name of Minor: ____

Please use a separate form for each child. Update yearly. Return in person of by mail to:

McDonough District Hospital - Volunteer Office – 525 E. Grant Street – Macomb, Illinois 61455

EMERGENCY MEDICAL CARE FOR YOUR CHILDREN

Parents need to do everything possible to make sure they can be reached at all times. But occasionally, the reality of traveling or shopping makes this impractical. Therefore, an authorization form such as this should be completed for each child. Copies need to be left with any adult who cares for your child – babysitters, teachers or school principals, relatives, etc.

AUTHORIZATION OF CONSENT TO MEDICAL TREATMENT FOR MINOR CHILD

I (we), ____, a parent / legal guardian of ____, a minor born ______________________, residing at ____, telephone number ___________________, consent to medial, surgical or diagnostic procedures the physician deems necessary to be rendered to this minor when the need for such treatment is immediate.

CHILD'S DOCTOR: ___________________________ **CITY:** __________________ **PHONE:** _______________

PARENT'S DOCTOR: _________________________ **CITY:** __________________ **PHONE:** _______________

ALLERGIES TO MEDICINE: ____

MEDICINE / DOSEAGE CHILD IS TAKING: ____

IT IS REQUIRED THAT WE HAVE A CURRENT IMMUNIZATION RECORD ATTACHED TO YOUR APPLICATION.

____ ____________________

Signature of parent / legal guardian **Date**

Others to be notified:

Name: ____ **Name:** ____________________________________

Address: ______________________________________ **Address:** __________________________________

_______________________________________ __________________________________

Phone: ____ **Phone:** ___________________________________

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