Black River Health

Dear Prospective Volunteen,

Thank you for your interest in the Volunteen Program. Being a Volunteen is a very rewarding experience. In addition to the satisfaction you receive from helping others, you will also gain insights into the medical field as a possible profession.

To be a Volunteen, you must:

1. Be 14-18 years old
2. Complete the application containing your signature and that of a parent or guardian
3. List two (2) personal references (individuals who are over 18 years old and not a member of your immediate family)
4. Attend the general orientation session on Tuesday, June 10, 11:30am-3:30pm at the hospital
5. Complete the health history form
6. Must be in good academic standing in school
7. Accept your assignment in good faith and be present when scheduled or arrange for a replacement; volunteering is a commitment

You will receive a letter with details prior to the general orientation. If you have any questions, please contact Sarah Osegard at 715-284-3606 or email osegards@blackriverhealth.com.

We look forward to meeting you!
Sincerely,

Sarah Osegard
Volunteer Coordinator

Please return the completed application packet (application, permission form, personal release, and health record) by May 15, 2025 to:

Black River Memorial Hospital
Attn: Sarah Osegard
711 West Adams Street
Black River Falls, WI 54615

Black River Health

VOLUNTEEN APPLICATION

Date: _____

Name: _____

Address: _____
Street City State Zip

Phone Number: _____ Age: _____

School Attending: _____

Present Grade Level: _____ Expected Graduation Year: _____

School Activities: _____

Other Activities: _____

Career Plans (if any): _____

Currently Employed? ☐ Yes ☐ No Hours Per Week: _____

Name of Employer/Company: _____

Do you have any physical restrictions, limitations, or health issues which may affect your ability to perform the necessary requirements of Volunteen duties? ☐ Yes ☐ No

If yes, please describe: _____

_____

Describe your interest in being a Volunteen: _____

_____

List two (2) character references, not relatives (teacher, employer, etc.):

Name	Mailing Address	Phone
1.		
2.		

I understand that if accepted as a Volunteen, it is my responsibility to read the rules and regulations for Volunteens, to be prompt and regular in my service, and to perform my assigned duties to the best of my ability.

Signature: _____ Date: _____

Black River Health

VOLUNTEEN PROGRAM
PARENTAL PERMISSION

Date: _____

I hereby give permission for my child, (name) _____, to participate in the Volunteen Program at Black River Health (BRH). I certify that my child is _____ years of age and that his/her birthdate is _____.

I authorize any health screening that is required for participation in the Volunteen Program.

I understand that as a Volunteen, my child is making a commitment to Black River Health. He/she has an obligation to carry out the responsibilities he/she undertakes. I will take part in this commitment by assuring that he/she will report on time for assignments. I will also make sure notice is given when he/she cannot be there at the scheduled time.

To volunteer at Black River Health, my child will attend the general orientation session on Tuesday, June 10, 2025, 11:30am-3:30pm at the hospital.

My child will return the permission forms, personal release, and health record by June 4, 2025.

Parent/Guardian Signature: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Black River Health

CONSENT TO PHOTOGRAPH, INTERVIEW, AND/OR VIDEO

I hereby consent Black River Health, Inc. and its agents, staff, and representatives to make, use, edit, reproduce, and publish any of the following (strike if not applicable): photographs, video, verbal comments, written comments, recorded interview, and other audiovisual records of me. I consent to and authorize the use of these items in the following manner (strike if not applicable): internal publications, community or public announcements, internet/website, email, social media, release to the media, and patient and medical professional education. This consent shall act to expressly release from liability Black River Health, Inc., any and all of its staff, its agents, representatives, consultants, and physicians.

Name (printed): _____

Address: _____
Street Address

_____
City State Zip

I am over 18 years of age: ☐ Yes ☐ No* Phone: _____

_____ _____
Signature of above-named person Date

_____ _____
Witness Signature Date

*If the above-named person is under 18 years of age or is otherwise unable to consent, consent should be given by parent or guardian as follows:

I hereby certify that I am the parent/guardian of: _____

This person is unable to consent because: _____

For the above-named person, I do hereby give my consent and authorization to the foregoing on behalf of him/her/them.

_____ _____
Signature of parent/guardian Date

_____ _____
Signature of witness Date

Black River Health

VOLUNTEER SERVICES HEALTH RECORD

Name: _____ Phone: _____

Address: _____
Street City State Zip

Emergency Contact Name: _____ Phone: _____

Date of Birth: _____

ALLERGIES

☐ Food – Please specify: _____
☐ Medications – Please specify: _____
☐ Latex
Describe your reaction(s) to the items listed above: _____
_____

CHILDHOOD ILLNESSES

Have you ever had any of the following illnesses?

☐ Measles ☐ Rubella (German Measles) ☐ Whooping Cough
☐ Scarlet Fever ☐ Polio ☐ Mumps
☐ Shingles ☐ Other: _____

IMMUNIZATIONS

Provide the dates of when you received the following immunizations, TB testing, or immune titer records. If records are not available, a blood draw will be performed, at no cost to you, to determine immunity status.

Measles MMR: 1) _____ 2) _____ OR Titer Results: _____

Mumps MMR: 1) _____ 2) _____ OR Titer Results: _____

Rubella MMR: 1) _____ 2) _____ OR Titer Results: _____

Varicella/Chicken Pox Status: _____ OR Titer Results: _____

Hepatitis B Status: _____

Tetanus Date: _____ ☐ Tdap or ☐ Td
Optional

To the best of my knowledge, I am free from contagious disease and know of no condition which would prevent me from performing volunteer activities. I further consent to pre-service laboratory testing and vaccination, if indicated.

Signature: _____ Date: _____