



Youth Companion Program Application

Date_____

Name: Last_____ First_____

Address: _____ City_____ Zip_____

Date of Birth:_____

Email Address:_____

Parents Name: _____ Phone_____

Year in School: _____ Name of School: _____

What year will you graduate? _____

List any previous volunteer work you have been involved in: _____

Do you have any parents or relatives employed by Memorial Hospital? Y__ N__

If yes, what department? _____

Why do you want to become a Memorial Hospital Volunteer? _____

Please list two references:

Name:_____ Phone_____

Name:_____ Phone_____

The above named applicant is recommended for Volunteer Services at Memorial Hospital.

Signature of School Counselor:_____ Date_____

Phone Number:_____

Youth Companion Consent Form

- By signing this I authorize, _____, a minor, to participate in the Youth Volunteer Program at Memorial Hospital. Such activities are under the supervision of the hospital's Supervisor of Volunteer Services.
- I (we) understand that this minor's services are donated to the hospital, without expectation of reimbursement, and given for charitable, humanitarian, or religious reasons.
- I (we) give permission for the above-named minor to submit to a drug-screen, tuberculin skin test (PPD) or other blood test which is required to serve at Memorial Hospital. It is understood that this required test is given at the hospital's expense.
- I (we) authorize the Emergency Department physicians as my(our) agents to consent to any X-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care which is deemed advisable in an emergency situation.
- I(we) release Memorial Hospital and its employees from any claim of liability for any damages, injury, or illness resulting to the above-named minor, not resulting from any fault or neglect on the part of the hospital, while engaging in designated Youth Volunteer activities.
- This authorization and permission shall remain effective for the period of time the above-named minor is a Youth Volunteer at Memorial Hospital.

Parent/Guardian Signature(s)

Date