Parental Consent Form

Junior Volunteer’s name: ____________________________

PLEASE PRINT

Age: ____________

Please read and check (v) each item below. A parent/guardian must sign this form in order for the child to participate in the summer program.

___ I hereby permit my child to participate in the Junior Volunteer Program of Novant Health UVA Health System and attend all activities conducted by the Novant Health UVA Health System Volunteer Services.

___ I understand that my child will be exposed to a variety of patient experiences.

___ I understand that in order to participate in the Junior Volunteer Program, my child must have completed all health requirements by the assigned deadline.

___ In consideration of Novant Health UVA Health System allowing my child to participate in this Junior Volunteer Program, I hereby, for myself, my heirs, executors and administrators, agree to release, waive, discharge, covenant not to sue, hold harmless and indemnify Novant Health UVA Health System, Novant Health UVA Health System and Novant Health Auxiliary, and their respective officers, staff members, employees, agents, directors and members, from and against any and all claims, suits or causes of action arising from or out of any physical or mental injury that my child or I may suffer as a result of participation in this program, which is not a result of negligent or willful acts by Novant Health UVA Health System, its agents or employees.

___ In case of a medical emergency, I hereby permit my child to be treated at Novant Health UVA Health System.

_________________________________________        ____________________________
Parent or Guardian Signature                             Date

_________________________________________
Print Name
Junior Program Agreement

Name: __________________________________________

Dept./Shift Assigned: _______________________________ 

- I understand I will be serving as a Junior Volunteer at Novant Health UVA Health System and will abide by the policies and procedures of the Novant Health Auxiliary in accordance with the policies and procedures of Novant Health UVA Health System.

- I understand that in order to participate in the Junior Volunteer Program, I must attend my assigned interview, orientation and training dates.

- I agree to wear my aubergine polo shirt with black dress pants, black shoes and my badge. My attire will be neat and professional. Long hair will be braided or in a ponytail. Nails are neat and trimmed. No strong scents, perfume or false nails are allowed.

- I understand that I am committing to volunteer the shift assigned to me. My shift may change at the discretion of the department according to the department/unit need.

- I agree and understand that I will volunteer the shift and area assigned to me within my position description, and may be asked to perform additional responsibilities on occasion as requested.

- I understand that I am responsible for clocking in/out on days I volunteer.

- I understand the requirement to complete a TB questionnaire, receive a flu vaccination during flu season, and complete our Annual Mandatory Education (AME) as requirements to continue as a volunteer with Novant Health UVA Health System.

- I understand that I am placed in the Junior Volunteer program for a period of one year. I understand that my service can be terminated by me if the position/program is not suited for me or by the Auxiliary, if I fail to follow policies and procedures.

Volunteer Signature: _____________________________ Date _________

Parent Signature: _________________________________ Date _________
VOLUNTEER SOCIAL MEDIA POLICY

Communication about Novant Health that is posted online by volunteers must be consistent with Novant Health policies and applicable laws, including laws concerning protected health information, privacy, confidentiality, copyright and trademarks. Violation of Novant Health’s Social Media policy may result in dismissal from our volunteer program.

Guidelines for Personal Social Networking

When you communicate online:

1. **Follow all applicable Novant Health policies.** For example, you must maintain patient privacy and never share confidential information about Novant Health. It’s OK to talk about your volunteer role – it’s fun to share things that make you proud – but anything you say that could identify a patient violates confidentiality and is against Novant policies and federal law.

   The HIPAA policy is the one that is most likely to get people in trouble. Everyone knows they can’t mention a patient’s name in their online (or other) activities, but there is a lot of other information about a patient that is considered protected health information and cannot be disclosed. The key is to remember that **anything** that could identify a patient to someone is a privacy violation.

2. **Do not identify yourself with Novant Health** if your blog, posting or other online activities are inconsistent with or would negatively impact Novant Health’s reputation or brand.

3. **Always respect others.** Be courteous and professional. It’s all about judgment: using your online postings to degrade others isn’t smart or professional.

4. **If you think a post might be inappropriate, it probably is.** Ask the volunteer coordinator about appropriateness if you have any questions. Remember that if you wouldn’t want others from Novant Health to see your comments, don’t post them online.

5. **Be a “scout” for compliments and criticism.** You are one of our most vital assets for monitoring the social media landscape. If you come across positive or negative remarks about Novant Health or our brands online that you believe are important, consider sharing them by forwarding them to your volunteer coordinator or to socialmedia@novanthealth.org.

6. **Be conscious when mixing your personal life with your volunteer life.** Novant Health respects the free speech rights of all of its employees and volunteers, but you must remember that patients, employees and fellow volunteers often have access to the online content you post. Remember that information originally intended just for friends and family can be forwarded.

   *(Please keep this policy for future reference.)*
SOCIAL MEDIA POLICY

I have read and understand the contents of the Social Media policy and agree to adhere to the policy.

__________________________________  ________________________
Junior Volunteer Signature           Date

__________________________________
Junior Volunteer Name (Please Print)

__________________________________  ________________________
Parent/Guardian Signature           Date

__________________________________
Parent/Guardian Name (Please Print)
Permission to Use or Share Personal Information & Photo for Marketing Purposes

I give permission to use or share photos of me as described below.

A. YES ________  B. NO ________

1. Who is permitted to use or share this information? This will include employees

   of Novant Health UVA Health System. I also understand that this information is held in strictest confidence, in accordance with federal and state law.

2. Who is permitted to receive this information? This will include Employees & volunteers of Novant Health, viewers of Novant Health UVA websites, social media outlets such as Facebook & YouTube.

3. What kind of information may be shared? This includes my name with my location of service.

4. Why is this information being shared? This information will be used as part of a marketing/social media and/or media campaign about providing a remarkable patient experience. For promotional and marketing materials, including brochures, fliers, articles, newsletters, press releases, etc.

   This information may be distributed to Employees of Novant Health UVA facilities, viewers of any NHUVA website and NH social media sites including Facebook and YouTube and other community websites.

5. I may refuse to sign this authorization and that my refusal to sign will not affect my ability to volunteer. I may obtain a copy of any information that has been used or released under this authorization.

6. I have the right to change my mind. I may revoke this authorization in writing at any time by submitting such a request to Novant Health UVA Health System Volunteer Services Office 8700 Sudley Road, Manassas, VA 20110. This authorization expires upon resignation.

7. I have read and understand this information. I have received a copy of this form. I am the Volunteer.

______________________________  _______________________
Print Name of Teen Volunteer                           Date

______________________________
Parent / Guardian Signature

Permission to Use or Share Information for Marketing Purposes

1/20/20
Junior Volunteer Program Immunization History and Clearance

Name of Applicant: __________________________________________________________

Date of Birth: ___________________________  Phone: ___________________________

Address of Applicant: ____________________________________________________________________________

*To the provider: Please fill in dates; the first two immunizations are required

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<td>Chicken Pox* (Varicella)</td>
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<td>Mumps Vaccine</td>
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<td>TB Skin Test</td>
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<td>BAMT Blood Assay</td>
<td>Results</td>
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Applicant is cleared to participate in the Summer Teen Volunteer Program. _____YES _____NO
If there are any restrictions, please list:

Provider’s Signature: ___________________________  Date: _______________________

Practice’s Name: ___________________________________________________________

Practice Address: ___________________________________________________________  Phone: ________________

**Please Note:** An official immunization record may be substituted, provided the information requested above is included. Said record must have either a physician/medical practitioner signature or a medical practice verification stamp.
Statement of Attestation Form- Seasonal Influenza Vaccine

Influenza Vaccination Requirement:
I understand that Novant Health UVA Health System requires an influenza vaccination as a condition of volunteering throughout the year.

Acknowledgement:
- I can request a copy of the Novant Health UVA Health System Influenza Vaccination policy from the Volunteer Services office.
- I understand that an annual flu vaccination is a requirement.
- I agree to provide a flu vaccination for my child at my expense.

Volunteer Name (Printed) ________________________________
Volunteer Signature ________________________________
Parent Signature ________________________________
Date of review ________________________________
Novant Health Employee Occupational Health
TB Screening Tool for Health Care Workers (HCWs)

_________________________________________   __/__/____   __________
Last name, first name          Date of birth     ID#

☐ Employee  ☐ Volunteer  ☐ LIP (medical staff)   (_____)(____)__________
☐ Contractor  ☐ Student  ☐ other_______   Best contact number

Symptoms of active TB disease (check all that are present)
☐ Coughing (>3 weeks)  ☐ Chest pain  ☐ Fatigue
☐ Night sweats  ☐ Coughing up blood
☐ Weight loss/poor appetite  ☐ Fever/chills

HCW's history (check response)
Have you ever had a positive reaction to a TB skin test or TB blood test? ☐ Yes  ☐ No
If yes: Date___________ Number of millimeters of induration_______

Have you had a TB skin test or TB blood test in the past 12 months? ☐ Yes  ☐ No
If yes for TB skin test: Date___________ Number of millimeters of induration_______ Result _______
If yes for TB blood test: Date________________________ Results _______

☐ Yes  ☐ No
 Have you ever had the BCG vaccine?

☐ Yes  ☐ No
 Have you ever been treated for latent TB infection?

☐ Yes  ☐ No
 Have you ever been treated for active TB disease?

☐ Yes  ☐ No
 Have you ever had an adverse reaction to a TB skin test?

☐ Yes  ☐ No
 Have you received a live-virus vaccine within the past 6 weeks?

☐ Yes  ☐ No

Comments

The above health statement is true and correct to the best of my knowledge. I will report if my health status changes. I understand that I must not report for duty if I have an infectious or contagious disease until it is resolved.

_________________________   __________________
Healthcare Volunteer Signature          Date

_________________________   __________________
Signature of Parent if less than 18 years of age  Date

_________________________   __________________
Signature of EOH personnel reviewing form  Date

2017.02.03