

UPMC Horizon

110 North Main Street
Greenville, PA 16125-1795
(724) 589-6675

2200 Memorial Drive
Farrell, PA 16121-9988
(724) 983-7505

STUDENT VOLUNTEER PROGRAM - SCHOOL REFERENCE

Please Print or Type

TO: _____ [] Teacher [] Counselor [] Other _____

RE: My child, _____ Grade in School: _____

Parental/Guardian Consent: I authorize the release of information from my minor son/daughter's school records to the Volunteer Services Department of UPMC Horizon.

Parent/Guardian's Signature _____ Date: _____

Dear Teacher or Counselor:

The above student has applied to the Student Volunteer Program at UPMC Horizon. Because this program only succeeds with mature, dependable, responsible and courteous students, each applicant is asked to submit two letters of recommendation. At least one recommendation must be from a teacher or counselor at the applicant's school who is familiar with the student.

The Hospital would appreciate your evaluation and frank comments to help us choose candidates who will best benefit from the program and serve the Hospital and the recipients of its services. This information will be kept confidential. Please return the completed form to the UPMC Horizon Volunteer Services Department in the attached self-addressed, postage paid envelope as soon as possible so the processing of his/her application can begin. Thank you.

UPMC Horizon Volunteer Services Department

To Be Completed By Student Applicant's Counselor/Teacher:

	<u>Excellent</u>	<u>Good</u>	<u>Average</u>	<u>Below Average</u>
Attendance	_____	_____	_____	_____
Scholastic Record	_____	_____	_____	_____
Dependability	_____	_____	_____	_____
Courtesy	_____	_____	_____	_____
Initiative	_____	_____	_____	_____
Character/Honesty	_____	_____	_____	_____
Maturity	_____	_____	_____	_____

How long have you known this student? _____ Your Position/Occupation: _____

School District: _____ Daytime Phone: () _____

COMMENTS: _____

Signature: _____ Date: _____

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STUDENT VOLUNTEER PROGRAM - PERSONAL REFERENCE

Please Print or Type

TO: _____, an unrelated adult acquaintance of student applicant.

RE: My child, _____, I authorize the release of information regarding my minor son/daughter to the Volunteer Services Department of UPMC Horizon.

Parent/Guardian's Signature _____ Date: _____

Dear Unrelated Adult Acquaintance of Applicant:

The above student has applied to the Student Volunteer Program at UPMC Horizon. Because this program only succeeds with mature, dependable, responsible and courteous student volunteers, each applicant is asked to submit two letters of recommendation.

At least one recommendation must be from a teacher or counselor at the applicant's school who is familiar with the student. The second reference may also be from a teacher, minister, friend of the family, extra-curricular group leader, or any other adult who is unrelated to the applicant but who has sufficient knowledge of the student to comment on his/her qualifications for the UPMC Horizon Student Volunteer Program.

The Hospital would appreciate your evaluation and frank comments to help us choose candidates who will best benefit from the program and serve the Hospital and the recipients of its services. This information will be kept confidential. Please return the completed form to the Hospital's Volunteer Services Department in the attached self-addressed, postage paid envelope as soon as possible so the processing of his/her application can begin. Thank you.

UPMC Horizon Volunteer Services Department

To Be Completed By Student Applicant's Unrelated Adult Acquaintance:

	<u>Excellent</u>	<u>Good</u>	<u>Average</u>	<u>Below Average</u>
Dependability	_____	_____	_____	_____
Courtesy	_____	_____	_____	_____
Initiative	_____	_____	_____	_____
Character/Honesty	_____	_____	_____	_____
Maturity	_____	_____	_____	_____

How long have you known the applicant? _____ Daytime Phone: () _____

How did you become acquainted with him/her? _____

COMMENTS: (Please type, print or write clearly) _____

Signature: _____ Date: _____

AUTHORIZATION FOR MEDICAL TREATMENT OF MINOR CHILD

In the event that I cannot be reached in an emergency, and my child acquires an illness or injury requiring immediate medical treatment, I give UPMC Horizon permission to provide emergency medical care and related services to my child,

_____, a minor, as deemed necessary by the agents and employees of the Hospital. The choice of a physician shall be at the discretion of the Hospital for all volunteer work related injuries. This Authorization shall remain effective while my child serves in the Hospital's Volunteer Program and until he/she formally withdraws, resigns or is terminated from the program, or until my child's eighteenth (18th) birthday, unless sooner revoked by me in writing delivered to the Volunteer Services Department of UPMC Horizon.

Signature of Parent/Guardian Date: _____

AUTHORIZATION FOR ADMINISTRATION OF TUBERCULOSIS TEST

I authorize UPMC Horizon to perform a tuberculin skin test on my child, _____, who is a minor, prior to acceptance in the Student Volunteer Program.

Parent/Guardian Signature Date: _____



OCCUPATIONAL MEDICINE DEPARTMENT USE ONLY

Date test performed: _____ Date test read: _____

RESULT: () Negative () Positive

Signature, Occupational Medicine Department Personnel