WINGS TO SOAR
VOLUNTEER APPLICATION

All information is strictly confidential.

Volunteer Camp applications will be considered for appropriate positions, by Camp Administrator.

NAME: _____

STREET ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

BIRTHDATE: _____ AGE: _____ GENDER: _____

SS# (required for background check): _____

T-SHIRT SIZE: Small____ Medium ____ Large ____ XL ____ XXL ____

CONTACT INFORMATION:

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ EMAIL: _____

IN CASE OF AN EMERGENCY, PLEASE CONTACT:

NAME: _____ RELATIONSHIP: _____

PHONE: (H) _____ (W) _____ (C) _____

* For background check you will receive an email from "My Certiphi". Please respond in a timely manner.

EDUCATION (Highest grade completed): _____

DRIVERS LICENSE #: _____

STATE: _____ ***EXPIRATION DATE***: _____

CAR INSURANCE CO: _____ POLICY #: _____

As a camp volunteer you will be exposed to many different types of deaths, which may bring up multiple emotions that may need processing. Please free contact Shea at any time pre, during and post camp if needed.

Position approved _____

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Health History

All information provided is strictly confidential. So that this information is readily available at camp, all staff and volunteers must complete this form in its entirety.

HEALTH HISTORY (please check all that apply):

☐ Allergies	☐ Emotional Problems	☐ Wears Contacts/Glasses
☐ Asthma	☐ Hearing Impairment	☐ Heart Disease
☐ Seizures	☐ Physical Limitations	☐ Special Dietary Needs
☐ Diabetes	☐ Motion Sickness	☐ Currently Taking Medication

Please explain any items that were checked or indicate any other useful information regarding your health:

_____

_____

Are you currently under a physician's care for a medical problem?	☐ Yes	☐ No
Do you carry an EpiPen?	☐ Yes	☐ No
Are you restricted from participating in any physical activity?	☐ Yes	☐ No

I know of no health reasons, other than information indicated on this form, why I should not participate in any of the Wings to Soar camp activities.

_____ _____

Signature Date

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Authorization for Emergency Medical Treatment

And Release of Liability Form

Should a medical emergency arise during my participation in Wings to Soar Camp and I am unable to speak for myself, I consent to:

1. The administration of medical treatment and/or surgical procedures deemed necessary by the medical doctor and/or medical facility identified below or chosen by the Camp Director, and
2. The immediate administration of life-sustaining measures deemed necessary under the circumstances.

_____ _____ _____

Name *(please print)* Signature Date

Health Insurance Information

Preferred Medical Doctor/Facility: _____

Address: _____

Phone: _____

Insurance Company: _____

Policy Number: _____

Policyholder's Name: _____

General Release of Liability

I understand and agree that Hospice & Palliative Care of Cabarrus County, Board of Directors, Employees and Volunteers are released from any legal responsibility and/or liability for negligence arising out of any accidents or illnesses which occur at the Wings to Soar camp.

_____ _____ _____

Name *(please print)* Signature Date

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EMPLOYMENT:

VOLUNTEER EXPERIENCE:

CLUBS/COMMUNITY ORGANIZATIONS/PROFESSIONAL AFFILIATIONS:

_____

_____

SPECIAL SKILLS AND TALENTS:

_____

_____

_____

FIRST TIME APPLICANTS ONLY:

NAMES OF 3 PEOPLE WE MAY CONTACT FOR REFERENCE:

1. NAME: _____ PHONE: _____
   STREET ADDRESS: _____
   CITY: _____ STATE: _____ ZIP: _____
   RELATIONSHIP TO APPLICANT: _____
   OCCUPATION: _____
2. NAME: _____ PHONE: _____
   STREET ADDRESS: _____
   CITY: _____ STATE: _____ ZIP: _____
   RELATIONSHIP TO APPLICANT: _____
   OCCUPATION: _____
3. NAME: _____ PHONE: _____
   STREET ADDRESS: _____
   CITY: _____ STATE: _____ ZIP: _____
   RELATIONSHIP TO APPLICANT: _____
   OCCUPATION: _____

Office Use:
Background check sent _____ Background check completed_____

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Volunteer Statement of Confidentiality and Non-Disclosure

Campers and families have a legal right to expect that confidentiality of information will be preserved. Unlawful use or disclosure of information may expose an agency to civil and criminal liability. Any breach of confidentiality must result in the automatic dismissal of a volunteer.

1. Confidentiality means that all information about a camper and family is protected.

   Protected information includes all information about a camper and family, including name, cause of death, address, financial information, family relationships and any information learned from the staff, camper, or family.

2. I *will not* disclose any information with anyone unauthorized to receive this information. I will handle all paperwork and forms with proper procedure of control so that no information is accidentally observed or released to any unauthorized persons. I also understand that the casual sharing of patient care information in public places or settings is inappropriate.

   Volunteers do not discuss the camper, emotional status, coping, or family information with anyone other than appropriate agency personnel. "What you hear and see here, stays here."

   Volunteers will discuss information only in private spaces and not in cafeterias, lobbies, waiting rooms, parking lots, or other public spaces in the agency, at the camp site or elsewhere.

   Volunteers must observe these cautions even if others occasionally forget them.

   Volunteers are not to initiate contact with or indicate that they know a camper or a camper's family in any place other than camp.

3. I *will* disclose such information only in the discharge of my assigned duties and responsibilities with Hospice or persons authorized to receive such information through the signed consent of patient, family member, or affected party.

   In your role as a camp volunteer, all matters should be kept confidential, except those matters related to instances of harm or threat of harm to any person, child abuse, or child neglect.

   No photographs or videotapes of any kind are permissible without a signed release form from the camper's parent or legal guardian. Volunteers must not allow anyone to photograph or videotape campers without staff permission and a signed photo consent form.

I understand that information regarding Hospice & Palliative Care of Cabarrus County patients, their families and/or significant others and any persons receiving bereavement support or services in any capacity is privileged information for use by and with authorized persons only. I further understand and agree that any violation of this policy is of such critical offense that it will justify my immediate discharge as a Wings to Soar camp volunteer.

_____	_____	_____
Name *(please print)*	Signature	Date