GURWIN JEWISH
NURSING & REHABILITATION CENTER

The Art of Caring. The Science of Care.

68 HAUPPAUGE RD • COMMACK, NY 11725
631-715-2555 • WWW.GURWIN.ORG

OFFICE USE ONLY:
Interview Date: _____ Interviewed by: _____
Assignment: _____
Proof of MMR: _____
Reference Sent: _____ Reference Returned: _____
Accepted Y or N: _____ Orientation Date: _____

TEEN VOLUNTEER APPLICATION

MUST BE AT LEAST 14 YEARS OF AGE

APPLICATION DATE: _____

APPLICANT INFORMATION:

NAME: _____

ADDRESS: _____
NUMBER AND STREET

_____
TOWN STATE ZIP CODE

TELEPHONE NUMBER: (HOME) _____ (CELL) _____

E-MAIL: _____ ARE YOU 14 YEARS OLD OR OVER?: _____

DATE AVAILABLE TO BEGIN: _____

SCHOOL INFORMATION:

HIGH SCHOOL: _____

ADDRESS: _____

CITY/STATE/ZIP CODE: _____

SCHOOL REFERENCE/TEACHER/GUIDANCE COUNSELOR: _____

GOALS FOR VOLUNTEERING: _____

INTERESTS/HOBBIES/TALENTS/EXTRACURRICULAR ACTIVITES: _____

SPECIAL SKILLS/OTHER LANGUAGES: _____

IS VOLUNTEERING A REQUIREMENT FOR COMMUNITY SERVICE? YES NO NO. OF HOURS: _____

Attached to this application, please provide proof of your first and second Measles-Mumps-Rubella inoculations. A physician's note on letterhead, prescription pad, or school health records will suffice.

You will be contacted by the Department of Volunteer Services to arrange your interview.

Mail completed application to:
Gurwin Jewish Nursing & Rehabilitation Center
Attn: Volunteer Office
68 Hauppauge Rd.
Commack, NY 11725
631-715-2555

_____
Signature of Parent/Guardian

_____
Print Name of Parent/Guardian

_____
Daytime Phone Number

_____
Address

_____
City/State/Zip Code

GURWIN JEWISH NURSING & REHABILITATION CENTER
NEW VOLUNTEER HEALTH ASSESSMENT

TO BE COMPLETED BY VOLUNTEER (PLEASE USE PEN)

Name_____

Male__Female_____Date of Birth_____

Address_____

_____

Telephone_____

Contact in Case of Emergency:

Name_____

Telephone #_____
Relationship_____

Name / telephone number of your Doctor/Clinic:

Name_____

Telephone_____

1. Are you currently under a doctor's care for any health condition? No___ Yes___
(describe)_____

_____

2. Are you aware of any health conditions/impairment which you **currently** have but for which you are not under a doctor's care? No____ Yes____
(describe)_____

_____

3. List any health impairments or disabilities which may be of potential risk to patients or other personnel or which might require the Center to provide reasonable accommodations in order for you to perform your duties.

_____

_____

4. Please list all medications you take regularly (include non-prescription or "over the counter" medications):

_____

_____

5. Are you habituated or addicted to depressants, stimulants, alcohol, narcotics or other substances which may alter your behavior? _____Yes _____No

6. Have you ever had or been treated for tuberculosis? No____ Yes____ (explain)

_____

_____

Do you suffer from: Unusual cough? Yes____ No____
Coughing up blood? Yes____ No____
Unexplained: fever Yes____ No____
Chills Yes____ No____
Night sweats Yes____ No____
Weight loss Yes____ No____

6. Have you ever received the Hepatitis B Vaccine (3 dose series)? ____Y ____N
If yes, date of 3rd Vaccine_____

DO YOU HAVE, OR HAVE YOU EVER HAD ANY OF THE FOLLOWING CONDITIONS (check every item).

	Yes	No		Yes	No
Fainting Spells or Blackouts			Epilepsy (Fits)/convulsions		
Shortness of Breath			Tightness in Chest/Chest Pain		
Asthma			Rupture of Hernia		
Hepatitis/Liver Trouble			Heart Trouble/Heart Attack		
Back Trouble/Back Aches			Knee Injury		
Allergies			Ruptured Disk		
Skin Trouble/Rashes/Etc.			Alcoholism		
Diabetes			Have you ever had any occupational illnesses or injuries?		
Are you now, or have you been disabled?			Have you ever been hospitalized for any illness or injury?		
Have you ever had any Military Service connected illness or injury?			Have you been hospitalized for any surgery?		
Have you ever had the chicken pox or 2 doses of the Varicella vaccine?			Have you ever had the Mumps or 2 doses of the Mumps Vaccine?		

If you have answered "YES" TO ANY OF THE QUESTIONS, PLEASE EXPLAIN FULLY BELOW.

_____

_____

I HEREBY CERTIFY: THAT THE INFORMATION I HAVE PROVIDED IS ACCURATE; THAT I AM NOT AWARE OF ANY PERSONAL HEALTH IMPAIRMENT WHICH MAY POSE A RISK TO NURSING HOME RESIDENTS OR PERSONNEL; AND THAT I AM NOT HABITUATED OR ADDICTED TO DEPRESSANTS, STIMULANTS, NARCOTICS, ALCOHOL, OR OTHER DRUGS OR SUBSTANCES WHICH MAY ALTER MY BEHAVIOR.

_____ _____

Volunteer Signature
(Parent or Guardian required if under the age of 18) Date

Reviewed by:

_____ _____

Medical Director/Designee Date

GURWIN JEWISH
NURSING & REHABILITATION CENTER

PARENTAL CONSENT FORM FOR INITIAL P.P.D. (MANTOUX)

In accordance with the New York State Department of Health requirements for volunteers in health care, I, the undersigned parent or guardian of_____
Name of junior volunteer

give permission for the administration of:

_____1. A two stage P.P.D. Mantoux skin test for tuberculosis. I understand that the test will be given in **two stages** approximately 14 days apart and must be examined by staff at the Gurwin Center within **48 hours to 72 hours** after administration.

_____2. A single stage P.P.D. Mantoux skin test for tuberculosis. *(Only applicable when documentation of a negative P.P.D. performed within one year has been provided to the volunteer staff.) & for* ***annuals***

A negative first stage P.P.D. MUST be documented prior to service at the Gurwin Center.

I give permission for my child to have a single view chest x-ray, to rule out active disease, if a positive reading of a P.P.D. (above 10mm) is found.

I understand that the Mantoux skin test and chest x-ray will be given, without charge, at the Gurwin Jewish Nursing & Rehabilitation Center.

Signature_____ Date_____
Parent/Guardian Signature

_____
name printed

Authorization for Administration of Mantoux Tuberculin (PPD)

To be completed by Volunteer:

Name: _____ Department:_____

Have you ever been told you have a positive reaction to a PPD?	YES	NO
Have you ever had a severe reaction to a PPD?	YES	NO
Female – Are you pregnant?	YES	NO
Have you had **ANY** exposure to a person known to have Tuberculosis?	YES	NO
Have you had **ANY** vaccine within the last (6) weeks?	YES	NO

If "yes" please give details, including dates:

_____

_____

_____ _____

Volunteer Signature Date
(Parent/Guardian required if under 18)

********** **FOR OFFICE USE ONLY**********

To be completed by Employee Health, MD, or NP prior to Administration:

I authorize administration of a one or two stage (P.P.D.) Purified Protein Derivative, 5TU intradermally, as medically appropriate, to the above named volunteer, provided there is no medical contraindication.

_____ _____

Signature/Title Date

VOLUNTEER
PHOTOGRAPHIC RELEASE FORM

Consent and permission is hereby granted to the Gurwin Jewish Nursing and Rehabilitation Center of Long Island, its agents and employees, and to any person, firm or organization that the center may designate or authorize, to take photographs or motion pictures of me.

This consent includes the use of such pictures, photographs or films with or without my name and biographical data concerning me by the Center or anyone else on its behalf, without limitation as to time or frequency of use, for any or all of the following purposes:

1. Newspaper release
2. Release to other media or communication
3. Educational, instructional or teaching purposes
4. Research activities
5. Publicity or fund raising
6. Internal Gurwin Center use

(Note: The signer may strike out any of the foregoing purposes not desired.)

Name:_____

Signature:_____

Parent Signature:_____

Date:_____