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 18 YEARS OF AGE

APPLICATION DATE: ______________

APPLICANT INFORMATION:

NAME: ______________

ADDRESS: ______________
NUMBER AND STREET

____
TOWN STATE ZIP CODE

TELEPHONE NUMBER: (HOME) ______________ (CELL) ______________

E-MAIL: ______________ ARE YOU 18 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.

____
Signature of Parent/Guardian

____
Print Name of Parent/Guardian

____
Daytime Phone Number

____
Address

____
City/State/Zip Code

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

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

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

*************************** **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:____