UNC
NORTH CAROLINA
JAYCEE BURN CENTER

BURN CENTER CHILDREN'S AFTERCARE PROGRAMS 2013

RETURNING VOLUNTEER FORM

Name: Mr. / Mrs. / Miss / Ms._____ Date _____
Last First Middle Initial

Date of Birth: _____Are you an IAFF member? Y N Gender: Female _____ Male _____

Home Address: _____
Street City State Zip County

e-mail address: _____

Telephone Numbers _____
Home Work Cell

Present Occupation: _____ Employer: _____

Past events you have volunteered for: _____

EVENT(S) YOU'RE VOLUNTEERING FOR: _____

SERVICE AREA PREFERRED:

___ Counselor to child (Must be at program **ALL** weekend) Age Range preference _____

___ Cabin leader ___ Activity area leader ___ Special Events

___ Logistics assistant ___ Counselor in Training (CIT) mentor ___ Willing to assist however needed

___ Other – Please specify _____

AVAILABILITY

___ All weekend (Required for Counselors) Days Only – Days and Times _____

___ Evenings only – Days and Times _____

Have you been convicted of a felony crime in the last year? Y/N

If yes, please explain_____

_____

BURN CENTER CHILDREN'S AFTERCARE PROGRAMS 2012
Volunteer Medical Information

Any medical conditions that the camp/ program nurse should know about:

_____

_____

Are there any restrictions on your activities? If so, please explain:

_____

_____

Allergies: (Penicillin, insect bites, bee stings, foods, etc.) List types and treatments.

_____

_____

Medications: Please list any medications that you are on:

_____

_____

Current immunizations required:

_____

_____

University of North Carolina
Health Care System
101 Manning Drive
Chapel Hill, NC 27514

_____

PATIENT PHOTOGRAPH/VIDEO AND
INFORMATION RELEASE AUTHORIZATION FORM – MIM #739

NOTE: This form is NOT required for photos or videos of patients used for the purposes of treatment or diagnosis, where the photo and/or video becomes part of the patient's medical record and is not used for any other purposes.

Photography/Videography Release:

I authorize the University of North Carolina Health Care System ("UNC HCS") to take photographs and/or videos, or to allow third parties to take photographs and/or videos, of _____ [patient name], for the following uses **(initial all that apply):**

For Public Relations Purposes:

_____ On UNC HCS internet and intranet sites
_____ In UNC HCS publications and brochures
_____ In the public media, such as newspapers, magazines, on the internet, and on television
_____ In presentations, publications, brochures, advertisements, or articles by non-UNC HCS agencies or companies, such as other non-profit organizations or for profit companies who provide support to UNC HCS

For Medical or Educational Purposes:

_____ In professional journals and other publications, including textbooks and electronic publications
_____ In presentations by UNC HCS faculty, staff, and employees, including professional and educational conferences or seminars
_____ In UNC classrooms and other teaching environments
_____ Other: _____

_____ (initial here) I understand that the image(s) I've authorized for disclosure may be seen by members of the general public. If I've authorized release of image(s) for medical or educational purposes, I understand that the images may be seen by scientists, medical researchers, and medical students and teachers, as well as by members of the general public.

Information Release:

_____ **(initial here)** **I understand that I may be identified by name in printed, internet or broadcast information that might accompany the photo or video image of me, and I consent to the use of my name.**

-OR-

_____ **(initial here)** **I do not consent to the use of my name. I understand that, even though my name will not be used, it is possible that someone may recognize me based on the image(s) alone.**

_____ (initial here) I authorize the use of the following information about me, my medical condition, or my treatment:

_____
_____
_____

PHOTOGRAPH/INFORMATION RELEASE AUTHORIZATION FORM

I understand that:

- I may revoke this Authorization at any time:
  - the revocation will not apply to information that has already been released in response to this Authorization.
  - I must revoke this Authorization in writing. The procedure for revoking this Authorization is to present my written revocation to the Office of Public Affairs & Marketing, UNC Hospitals, 101 Manning Drive, 6002 East Wing, Chapel Hill, NC, 27514.
- I may refuse to sign this Authorization:
  - UNC Health Care System will not condition my treatment, any payment, enrollment in a health plan, or eligibility for benefits on receiving my signature on this Authorization.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information may no longer be protected by federal and state privacy laws.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition:_____ (if left blank, this authorization will expire one year from the date it is signed).

I have read and understand the information in this Authorization form.

Signature of Patient:	
Printed Name:	**Date:**

OR

Signature of Authorized Representative:	
Printed Name:	**Date:**
Please explain Representative's authority to act on the behalf of the Patient: _____ _____	

Witness _____ Date _____