Orientation ____________ Volunteer No. ____________ Area **Burn Center Aftercare Programs**

UNC HOSPITALS
VOLUNTEER REGISTRATION FORM
2019

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

Date of Birth: _________________ Gender: Female ______ Male _______

Home Address: ____
Street City State Zip County

e-mail address: ____

Telephone Numbers ____
Home Work Cell

Present Occupation: _________________________________ Employer: _____________________________________

Education: (circle one)
High School Professional/Technical School _______________________________

College: Degree ____________________________ Major ____

EVENT(S) YOU'RE VOLUNTEERING FOR: __Camp Celebrate__________________________________
Is this your first year volunteering with us? Y___ No___ # of years of service___
PREFERRED volunteer assignment:

___ Counselor to child (Must be at camp **ALL** weekend) Age Range preference ___7-9yo ___ 10-12yo ___teens

___ Cabin leader ___ Co-Cabin Leader __photo/video team
___ Logistics assistant ___ Counselor in Training (CIT) mentor ___ willing to assist however needed

___ Other – Please specify ____

REFERENCES: Please provide 3 NON FAMILY MEMBER REFERENCES with knowledge of your character, experience, work habits, and abilities. Include EMAIL ADDRESS. Please write legibly.

Name	Relationship	Telephone Number	Email Address
Name	Relationship	Telephone Number	Email Address
Name	Relationship	Telephone Number	Email Address

EMERGENCY CONTACT: ___________________________ Best phone #: ___________________Relationship_____________________

ADULT T-SHIRT SIZE: ___ SMALL ___ MEDIUM ___ LARGE ___ X-LARGE ___ XX LARGE __XXXLARGE

PERSONAL SKILLS, AFFILIATIONS, ABILITIES AND KNOWLEDGE: Check all that apply.

__ Student __ Professional __ Firefighter – Department _______________
__Jaycee __ Community Volunteer __ Parent or relative of burn survivor
__ Burn Survivor __ Medical __ Friend of burn survivor
__ EMT __ Hospital Volunteer __ Other _______________________________

Are you a member of the Professional Firefighters of NC? __ Yes, Local Number _______ Are you an IAFF member? Y N

Swimming ability? Please check: __I don't swim __ not well __ ok __good __very well

Are you willing to swim in the pool and/or lake with the campers even if its cold? ___Yes ___No

Are you a Certified Lifeguard: __ Yes __No Have you had water safety experience? __Yes __No

List your water safety experience: ____

List any other helpful information about yourself ie: Languages spoken, camp skills, specialties, interests:

____

CAMP AND/OR LEADERSHIP EXPERIENCE

Dates	Camp & Director	Location	Camper or Staff

Applications due to the Burn Center by March 15th, 2019. <u>Registration may close earlier!</u>

If you have any questions regarding Children's Aftercare Programs, please contact Michele Barr at:
Michele.barr@unchealth.unc.edu 919.962.8427

Harassment: The Burn Center Aftercare Program's policy is to prohibit all forms of harassment by our employees and volunteers. This includes sexual, racial, religious and other forms of harassment of any person including, but not limited to, workplace harassment. Have you ever been accused of harassment of any person including, but not limited to, workplace harassment? (Note: Prior accusation or conviction is not an automatic bar to participation. The type of conviction or accusation and when it occurred will be evaluated by the program before any decision is made.) ___ Yes ___ No Explain:

____

____

____

____ _______________________

Volunteer Signature Date

12/16

Volunteer Name:____
First Last

☐ Male ☐ Female Birthdate: _____/_____/_______

Health Form for Camp Participation

Is Volunteer covered by medical insurance? ☐ Yes ☐ No

Insurance Co: ______________________________ Policy Holder: ______________________ Policy # _______________

Please indicate any pertinent information or requests regarding medical conditions which may limit or alter camp participation. All medications must be turned into the Camp Nurse for the safety of the campers.

Activity Restrictions:

Dietary Restrictions:

Medical Treatments/ please list any medications you are taking:

ALLERGIES: Do you have any known drug, food or environmental allergies? ☐ Yes ☐ No
(medications, peanuts, poison ivy, bee stings, etc)

If yes, please specify allergy and type of reaction:

EMERGENCY AUTHORIZATION:
I hereby give my permission to the medical staff at *Camp Celebrate* to order xrays, routine tests, and routine treatment for me/my child. In the event I cannot be reached in an emergency, I hereby give permission to the medical staff to hospitalize, secure proper treatment for, and to order injections, anesthesia, surgery for me/my child named above. I understand and accept that UNC Hospitals and *Camp Celebrate* may use Personal Health Information (PHI) for purposes of treatment, payment, and health care operations. I hereby give permission for necessary PHI to be released to insurance carriers, health care treatment facilities, and other professionals. This includes PHI from pharmacies, hospitals and clinics.

Signature of volunteer (Parent of CIT): ____ Date: _______________

IMMUNIZATIONS: Month/Year of last Tetanus immunization (DPT,DT,T) __________________ __________________

(Tetanus shot within past 10 years required for participation at camp.) Month Year

Volunteer Name:

First Last

HEALTH HISTORY

General health history: check "yes" or "no" for each statement. Explain "yes" answers below.

Do you have or have you had any of the following in the past 6 months?	**YES**	**NO**
1. Chronic or recurrent illness?	☐	☐
2. Illness lasting over one week?	☐	☐
3. Hospitalizations?	☐	☐
4. Surgery?	☐	☐
5. Recent infectious disease?	☐	☐
6. Recent injury?	☐	☐
7. Asthma/wheezing/shortness of breath?	☐	☐
8. Diabetes?	☐	☐
9. Seizures?	☐	☐
10. Frequent Headaches/Migraine?	☐	☐
11. Orthopedic injury/abnormality?	☐	☐
12. Problems with heart/blood pressure?	☐	☐
13. Chest pain with exercise?	☐	☐
14. Fainting or dizziness?	☐	☐
15. Concussion/unconsciousness?	☐	☐
16. Heat stroke/exhaustion/problem with heat?	☐	☐
17. Head Lice. Date cleared:	☐	☐

Please explain all "yes" answers:

Return all forms ASAP via mail, email, or fax

Email: maria_albani@med.unc.edu

Fax: 984-974-1870. ***Please email us to confirm receipt if you fax it in!***

Mailing address:
Camp Celebrate
North Carolina Jaycee Burn Center
101 Manning Drive, Campus Box 7600
Chapel Hill, NC 27599-7600

ACTIVITIES SHEET

Camp Program Skills

We need our volunteers to help in a variety of ways during camp, this might mean time away from your cabin to help out! Please let us know about your skills. Activities offered at each camp will vary.

In the following list please indicate the following:

"T" for those activities you can organize and teach as an expert
"A" for those activities in which you can assist

Adventure/Challenge

___ challenge/Ropes course
___ climbing/rappelling
___ low ropes teambuilding

Arts/Crafts

___ tie dye
___ drawing/painting
___ beading
___ scrapbooking
___ other: please list
____

Camp Craft/Pioneering

___ geocaching
___ hiking
___ orienteering
___ outdoor cooking
___ outdoor living skills

Drama

___ theater
___ skits

Music

___ singing
___ instrument (list)
___ ______________
___ ______________

Photography

___ 35mm
___ digital
___ video camera
___ making slide show
___ 360 camera knowledge
___ virtual reality, gear VR
___ drone

Sports/Fitness/Games

___ exercise
___ yoga
___ archery
___ baseball/softball
___ bicycling/biking
___ fishing
___ football
___ basketball
___ capture the flag
___ informal games
___ martial arts
___ swimming instruction
___ soccer
___ track/field
___ volleyball
___ chess
___ ice breakers – I can lead one!

Waterfront Activities

___ canoeing

___ kayaking

___ stand up paddle board

__ Yes, I am willing to print pictures, sort pictures, or help with behind the scenes tasks

PERSONAL QUESTIONNAIRE (complete if you have been to Camp Celebrate as a counselor for 3 years or less)

What contributions do you think you can make to the Burn Center Children's Aftercare Program? Help us understand your interest in volunteering at Camp Celebrate.

Write a brief biographical sketch, including experience in camp settings, training in camping, and experience or training in other fields, which might have a bearing on the position(s) for which you are applying. Attach a separate sheet if necessary.

Authority for Release of Information

PLEASE PRINT LEGIBLY!

NAME (First, Middle, Last) | MAIDEN NAME | SEX (M or F)

SOCIAL SECURITY NUMBER
(must have to volunteer, unless international student) | DATE OF BIRTH (month/day/year)

HOME ADDRESS (not school address and no P.O. Box) | At this address since (month & year)

CITY, STATE, ZIP

PREVIOUS ADDRESS (if home address is less than 1yr) | At this address for how long?

CITY, STATE, ZIP

APPLICANT AUTHORIZATION

I hereby authorize UNC Health Care to utilize a Consumer Reporting Agency (CRA) to perform a criminal record search.

I understand that the CRA does not guarantee the accuracy or timeliness of the information obtained from other sources and that UNCHCS and the CRA shall not be liable for any inaccuracy in the information obtained from the CRA.

____ ________/________/________

APPLICANT'S SIGNATURE DATE

Please understand that your volunteer placement is pending this background check and cannot be guaranteed.

Revised 5/16

Confidentiality Statement

It is the policy of the UNC Health Care System and its affiliates (individually and collectively called “UNCHCS” herein) that users (i.e., employees, medical staff, students, volunteers, vendors, outside affiliates, and any others who are permitted access) shall respect and preserve the privacy, confidentiality and security of confidential information (“CI”). In the course of providing services for or at UNCHCS, I may encounter these types of CI: (1) patient information (such as medical records, billing records, and conversations about patients), (2) personnel information (payroll, discipline or other information about employees, volunteers, students, contractors, or medical staff), (3) confidential business information of UNCHCS, its affiliates, and/or third parties, including third-party software and other licensed products or processes, or
(4) operations, quality improvement, peer review, education, billing, reimbursement, administration, or research (such as utilization reports, survey results, and related presentations). This information from any source and in any form, including, but not limited to, paper record, oral communication, audio recording, and electronic display, is strictly confidential. **I understand and agree that I will only access, maintain, use or disclose CI on a legitimate job- related, need-to-know basis, and that I will limit my access, maintenance, use or disclosure of CI to the minimum amount of CI necessary to accomplish the intended purpose of the use, disclosure or request.**

I further agree that:

1. I will I will protect the privacy, confidentiality and security of UNCHCS patient information, including electronic medical records cords (“EMR”), in accordance with federal and state regulations and applicable policies and procedures.
2. I will complete all required privacy and security training for accessing EMR or other CI.
3. I will not maintain CI on a mobile device (laptop, smartphone, tablet, etc.) that is not encrypted and will not electronically transmit CI in an unsecured manner or to an unencrypted mobile device.
4. I will not disclose to another person my sign-on code and/or password, and will not use another person’s, for accessing EMR or other CI. I will not leave a secured application unattended while I am signed on.
5. I will not attempt to access a secured application or restricted area without proper authorization or for purposes other than official UNCHCS business.
6. I will not alter or destroy CI unless alteration or destruction is part of my job or services for UNCHCS, in which case I will only alter or destroy CI in accordance with applicable policies and procedures.
7. I will immediately report to my supervisor any known or suspected (a) use of my password by someone other than me, or (b) inappropriate access, use or disclosure of CI.
8. I will safeguard from loss, theft, or unauthorized use/access UNCHCS owned equipment/property on which CI is stored or through which CI may be accessed.
9. I will not store or transmit CI via my personal equipment/property unless permitted by and in accordance with applicable policy or procedure.
10. I will not post or discuss CI of any type to social media sites unless pre-approved by UNCHCS.
11. I will not take photographs, make videos, or make other recordings of patients, staff, or visitors except in accordance with applicable UNCHCS policies and procedures.
12. I understand that my access to CI and my UNCHCS email account may be audited.
13. I will not access or obtain my own, a friend’s, or a family member’s patient information maintained by UNCHCS without appropriate written authorization and under applicable policies and procedures.

I agree that I have read, understand and will comply with the terms of this Confidentiality Statement and all applicable policies and procedures. I understand that my failure to comply with this Confidentiality Statement may result in termination of access to UNCHCS EMR, personal civil or criminal legal penalties, disciplinary action, up to and including termination of employment or student status, or loss of UNCHCS privileges or contractual or affiliation rights. AFTER MY EMPLOYMENT OR WORK AT UNCHCS ENDS, I WILL NOT TAKE ANY CONFIDENTIAL INFORMATION WITH ME AND I WILL NOT DISCLOSE ANY CONFIDENTIAL INFORMATION.

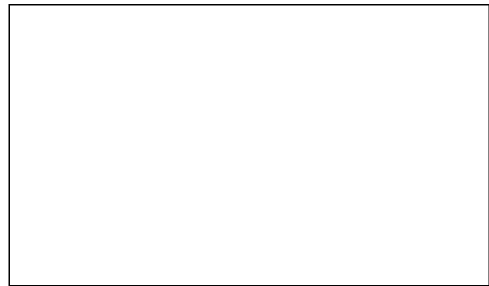
Name:____________________________________
(please print)

Employee ID or last 4 digits of SSN:__________

Signature:____________________**Date:** _________

Entity:
[ ] UNC Hospitals [ ] Rex Healthcare [ ] High Point Regional Health [ ] Pardee Hospital [ ] SOM [ ] Johnston Hospital [ ] Nash Hospital [ ] Chatham Hospital [ ] Caldwell Hospital [ ] UNC Physicians Network

Affiliation:
[ ] Employee [ ] Contract Employee [ ] Medical Staff [ ] Resident [ ] Referring Physician [ ] Student [ ] Other Providers [ ] Volunteer [ ] Vendor (specify):__________________________________



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

PATIENT RECORDINGS AND INFORMATION RELEASE AUTHORIZATION FORM (COMMUNICATIONS, MARKETING AND EXTERNAL AFFAIRS) – HIM #739s

I authorize UNC Health Care System and___________________[name of media outlet, as applicable] to take and/or release recordings (e.g., photographs, videos and/or audio), and related medical information, of _________________________________[patient name], for Public Relations and/or Marketing Purposes (including internet sites, publications, public media, presentations and advertisements). I understand that I may be identified by name, unless I initial the statement below.

___________ (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 recording(s) alone.

- I understand that I may revoke this Authorization at any time by sending a written request to the Office of Communications, Marketing and External Affairs, 211 Friday Center Drive, Chapel Hill, NC, 27517. Any revocation will not apply to information already released.
- I may refuse to sign this Authorization and UNC Health Care System will not condition my treatment 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. 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 in one year *or* on the following date, event, or condition**:**____**.**

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

Signature of Patient or Authorized Representative:	
Printed Name:	
Date:	**Time:**

Relationship of Authorized Representative to Patient (if applicable):

Witness ________________________________ Date: ________________________________ Time: __________