Texas Health Presbyterian Hospital PLANO

January 2024

Dear Junior Volunteer Applicant,

Thanks for your interest in Texas Health Plano 2024 Junior Volunteer Program. Students ages 16 to 18 are invited to apply.
The Junior Volunteer program at Texas Health Plano is based on community service and not career development. Most placements are in non-clinical departments and consist of support activities.
Make certain that you can commit to attending the mandatory Orientation and volunteer for two four-hour shifts per week for your entire session. Orientation is required for all volunteers to participate. This is a time to share our hospital's policies and procedures as well as familiarize you with our facility. Orientation also provides you the opportunity to meet other students selected for the program. Assignments will be given during orientation.

Important Program Dates:

- Mandatory Student Orientation----Thursday, June 6th ------10:00 AM to 2:00 PM
- Session----June 10th through July 25th (you will volunteer Monday/Wednesday or Tuesday/Thursday)
- Holiday-----July 1st through July 4th.
- All makeup dates must be scheduled and completed by July 31st.

You will be required to volunteer two four-hour shifts per week for a 6-week session earning 52 hours. You will have July 1st through July 4th.off meaning no students will be on campus. You are allowed one additional absence which must be made up to receive credit for the program. If you plan on being away (vacation, summer school, camps, etc.) for more than the allowed time, regretfully, your application will not be considered.

Next Steps:

- Virtual Parent/Student Informational Meeting

Thursday, February 15th 6:00 – 7:30 pm or Saturday, February 17th 7:30 – 9:00 am.

- Applications Due March 27th.
- Interview Notifications week of April 15th.

Remember .... Completed applications must be received by the March 27th deadline. Incomplete and late applications will not be considered. Applications can be returned in one of the following (3) ways:

1) Mail to------
Texas Health Presbyterian Plano Hospital
Volunteer Services/Junior Volunteer
6200 W Parker Road
Plano, TX 75093

2) Email to----THPVolunteerServices@TexasHealth.org

3) Fax to -Texas Health Presbyterian Plano Hospital/Volunteer Services/Junior Volunteer
(Fax) 972.981.0091

We are extremely excited at the possibility of you being a part of this year's team. This program is in high demand, so we appreciate your patience as we work through the volume.

Kindly,
Nateasie Kendrick
Manager of Volunteer Services

Texas Health Presbyterian Hospital PLANO

Junior Volunteer Application

(Please attach a small recent picture. Picture will not be returned)

Name: _____

Last First Middle

Address: _____

City & Zip: _____ Phone (student): _____

E-Mail Address: _____ Date of Birth: ____/____/____

Father/Guardian Address: _____

Daytime Phone: _____ Evening Phone: _____

Mother/Guardian Address: _____

Daytime Phone: _____ Evening Phone: _____

School Currently Attending: _____ GPA: _____Graduation Year: _____

Volunteer Experience: _____

Employer: _____

Extracurricular/Sports/Organizations/Hobbies: _____

Circle your preference:

Session:	June 10th through July 25th	
Days:	Monday/Wednesday	Tuesday/Thursday
Time:	8:00 am – 12:00 pm	12:00 pm – 4:00 pm

We will do our best to honor your preference but do know that all preferences are subject to availability:

1st Choice: _____

2nd Choice: _____

What size polo shirt do you need to purchase? Size_____

For office use only:

Date application received: _____ Assignment: _____

Paperwork Complete: _____ Shirt purchased: _____

Texas Health Presbyterian Hospital PLANO

Junior Volunteer Application

Why do you want to volunteer? What makes you the best applicant for this program?

_____

_____

Describe your two strongest attributes:

_____

_____

What career choices are you currently considering?

_____

_____

Have you applied to any other Texas Health summer programs? _____

If yes, which ones? _____

As a Junior Volunteer I understand that I am required to:

1) Be a student between the ages of 16 and 18.
2) Have a written consent from a parent or guardian.
3) Attend scheduled mandatory Junior Volunteer Orientation.
4) Follow all hospital rules and regulations as specified on the liability and Junior Volunteer agreement.
5) Volunteer two four-hour shifts for a six-week session totaling 52 hours.
6) Notify Manager of Volunteer Services IMMEDIATELY regarding any absences from duty. Failure to do so may result in termination from the program.

Signature of Junior Volunteer: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____

Texas Health Presbyterian Hospital PLANO

Junior Volunteer Application

PARENT/GUARADIAN---Please check the appropriate statements

_____ **I give permission for immediate emergency medical treatment. Notify me and/or any person listed as soon as possible.**

_____ **I DO NOT give permission for emergency medical treatment until I have been contacted.**

List all allergies, medication reactions or other conditions that may need to be known in an emergency.

_____

_____

_____

PARENT/GUARDIAN SIGNATURE: _____ **Date:** _____

Junior Volunteer Agreement

Texas Health Presbyterian Hospital Plano believes that all medical, financial, and personal information is confidential and is protected from unauthorized viewing, discussion, and disclosure. Therefore, team members, adult volunteers, and students may look at, use, or disclose patient's information ONLY as it relates to the performance of their duties. Any unauthorized viewing, discussion, or disclosure will provide grounds for immediate dismissal. Whenever it is questionable as to what information is confidential; it is your responsibility to discuss the matter with your supervisor before any breach of confidentiality occurs.

I acknowledge and have read the statement above and agree to abide by the expectations of the Junior Volunteer Program.

_____

JUNIOR VOLUNTEER SIGNATURE **DATE**

Texas Health Resources®

Manual Order – Background Check Application

Please complete the following required information for Texas Health to complete a background review. In addition, you will be asked to complete authorization forms.

Basic Information

First Name	
Last Name	
Date of Birth	
Social Security Number	
Phone	
Email	
Driver's License Number	
Driver's License Issuing State	
Address	
Country	
Zip	
State	
City	
County	

Texas Health Resources®

Criminal Records

Please provide information regarding any criminal findings which may appear on your record. If none, list N/A.	
Record Type (felony/ misdemeanor)	
Date of offense	
Description/Details	

Additional Names/Addresses

Please provide any additional names or addresses. If none, list N/A.	
Name(s)	
Addresses (within last 7 years)	

Please sign below to acknowledge the above information is true and correct.

Name: _____

Signature: _____

Date: _____

BACKGROUND CHECK AUTHORIZATION

To the extent permitted by applicable law, I hereby consent to and authorize **Texas Health Resources** and/or its subsidiaries, affiliates, other related entities, successors, and/or assigns (the "Company"), to procure consumer report(s), which may include criminal background check(s), investigative consumer report(s) (as defined by the federal Fair Credit Reporting Act), and/or investigative consumer report(s) (as defined by applicable California state law), on my background from a consumer reporting agency ("CRA") or from an investigative consumer reporting agency ("ICRA"), as described in the **Background Check Disclosure,** the **Additional Disclosures,** and the **California State Law Disclosures** (all of which I have received separately from the Company). I have reviewed and understand the information, statements, and notices in the **Background Check Disclosure**, the **Additional Disclosures**, and the **California State Law Disclosures**, as well as this **Background Check Authorization**. My authorization remains valid throughout my employment with the Company, such that, to the extent permitted by applicable law, I agree Company can procure additional consumer report(s), which may include criminal background check(s) and/or investigative consumer report(s) (as defined by federal law), during my employment without providing additional disclosures or obtaining additional authorizations. Except as otherwise prohibited by applicable law, I consent to and authorize the Company to share this information with Company's current or prospective clients, customers, others with a need to know, and/or their agents for business reasons (e.g., to place me in certain employment positions, jobs, work sites, etc.).

I understand that, if I am hired and begin work for Company, a consumer report will have been conducted on me.

For California, Minnesota, or Oklahoma applicants/employees only: If you would like to receive from the CRA, the ICRA, or the Company (as applicable) a copy of the report that Company may procure, please reach out to thrbackgroundcommittee@texashealth.org

Please sign below to consent, authorize, agree, and confirm your review and understanding, as set forth in this ***Authorization***.

Name: _____

Signature: _____

Date: _____

BACKGROUND CHECK DISCLOSURE

A consumer report is a background check in which information (which may include, but is not limited to, criminal background, driving background, character, general reputation, personal characteristics, and mode of living) about you is gathered and communicated by a consumer reporting agency ("CRA") to **Texas Health Resources** and/or its subsidiaries, affiliates, other related entities, successors, and/or assigns (the "Company").

Company may obtain a consumer report on you to be used for employment purposes.

Please sign below to acknowledge you have read the ***Background Check Disclosure***.

Name: _____

Signature: _____

Date: _____

Texas Health Presbyterian Hospital PLANO

VOLUNTEER AGREEMENT

Name: _____ Date: _____

Do you have any physical challenges or health problems that could limit your volunteer duties?

Yes ___ No ___ If yes, please explain so we may find the most suitable activity for you.

VOLUNTEER AGREEMENT

I understand that I am applying to be a volunteer, not a paid employee, within Texas Health Resources (THR). I understand that I am authorized solely to perform tasks assigned specifically to me. I understand I must follow all rules and regulations of THR. I understand that all information concerning THR, and its patients/residents is strictly confidential, and I hereby agree to maintain this confidentiality. I agree to accept full responsibility and to hold harmless Texas Health Resources (THR), its employees, directors, officers, trustees, or agents from any and all claims and damages that may arise from my participation in the volunteer program.

I understand that as a volunteer of Texas Health Presbyterian Hospital of Plano (THP), I may not provide volunteer services that involve direct patient care, and I may not provide volunteer services that require a license or certification. In addition, as a condition of volunteer placement, I may not solicit physicians on the THP medical staff or other clinical staff for "shadowing" or other educational opportunities. Such behavior may result in termination from my volunteer assignment.

I have read and understand the above and agree to comply with all rules and regulations of Texas Health Resources (THR) and the THP Volunteer Services Department. I understand that failure to comply with such rules and regulations may be cause for my removal from the volunteer program. I understand THP may terminate my volunteer services for any reason, or no reason.

Signature Date

Texas Health Presbyterian Plano* Volunteer Services Department

6200 W Parker Road* Plano, TX 75093* PHONE (972)981-8220

Texas Health Presbyterian Hospital PLANO

Volunteer Business Associate and Confidentiality Agreement

In your performance of your volunteer duties on behalf of a Texas Health Resources (THR) entity, you may have access to Confidential Information. Confidential Information is valuable and sensitive and is protected by law and by THR Policy. The intent of these laws and policies is to assure that Confidential Information will remain confidential – that is, that it will be used only by those with appropriate authority as necessary to accomplish the organization's mission.

Confidential Information is information concerning patients, participants of THR benefit plans and programs, customers, physician credentialing, peer review, quality review, committee records, personnel records, payroll records, salary and compensation information, logon and password information, employee health information and information related to operations and internal business affairs of THR that is not generally available to the public. You may learn of or have access to some or all of this Confidential Information through a computer system or through your volunteer activities.

Those requiring access to computerized information will be assigned a unique logon ID and password, as well as other control devices for any purpose will be kept secure and confidential. The unique logon ID and password are equivalent to a legal signature. Users will be held accountable for any access utilizing their unique logon ID. Access cards and other facility security devices will be kept secure.

You are required to conduct yourself in strict conformance to applicable laws and THR policies governing Confidential Information. Access to Confidential Information is permitted only as authorized and as required for legitimate purposes in the performance of your volunteer function.

Protected Health Information (PHI) is information related to patients and their health care, conditions, treatment, or payment. It extends to information that is transmitted or maintained in any form or medium, whether electronic paper or oral. All workers, whether directly involved in the care of the individual or providing support services, must use discretion when discussing PHI. PHI obtained should not be accessed or discussed unless absolutely necessary for work processes. Only PHI pertinent to the role of the volunteer's function should be accessed and communicated per THR Policy. If PHI is being discussed or otherwise inappropriately disclosed, the incident should be reported to a supervisor or the Entity Privacy Officer.

Violation of confidentiality can result in corrective action, up to and including termination. Release of PHI, without proper authorization could result in civil and/or criminal penalties.

I understand that my volunteer function may require access to Confidential Information and that is my role to secure and protect the information. I agree to safeguard and retain the confidentiality of all Confidential Information. I understand that without permission of my supervisor, I may not remove Confidential Information from the entity premises. If I have Confidential Information in my possession upon termination of my volunteer position, I will return it to my supervisor. I understand the consequences of confidentiality violations defined in THR Policy.

Signature: _____

Print Name: _____ **Date:** _____

Texas Health Presbyterian Hospital PLANO

Consent to be Photographed, Filmed, Videotaped and/or Interviewed and Release of Liability

I, the undersigned, hereby consent to be photographed, filmed, videotaped and/or interviewed while a patient, employee, volunteer, physician, or visitor of Texas Health Resources (THR) or any wholly owned member organization or an event sponsored by THR or one of its respective member organizations.

I agree that Texas Health Resources or any THR member organization may use or permit other persons to use the negatives, prints or video prepared from my photographs, words or written materials reflecting my interview for any purposes and in such manner as they may choose, including but not limited to use in informational or promotional materials about THR or any THR member organization, including:

- **News coverage by television, newspaper, radio, internet, or other media**
- **Video news releases**
- **Marketing materials**
- **Internal and external communication, including newsletters and video productions.**
- **Social media**

I understand that I will not be paid or reimbursed in any way for current or future use of my likeness, words, or ideas. I hereby give up any right to inspect or approve the finished product or products that may be used in connection therewith or the use to which it may be applied.

I HEREBY RELEASE AND AGREE TO HOLD HARMLESS TEXAS HEALTH RESOURCES (THR), ITS MEMBER ORGANIZATIONS AND THEIR TRUSTEES, OFFICERS, EMPLOYEES, AGENTS, PATIENTS, AND REPRESENTATIVES AND MEDICAL STAFFS OF THE THR HOSPITALS FROM ANY INJURY AND/OR DAMAGES SUSTAINED AS A RESULT OF SUCH PHOTOGRAPHING, FILMING, VIDEOTAPING AND/OR INTERVIEWING INCLUDING BUT NOT LIMITED TO, CLAIMS FOR PERSONAL INJURY, PROPERTY DAMAGE, INVASION OF PRIVACY AND/OR BREACH OF CONFIDENTIALITY.

I have read and understand this consent prior to signing.

Signature: _____ **Date:** _____

Please Print:

Name: _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip:** _____

Email Address: _____

Staff member name and signature completing the form (or witness)

Name: _____

Signature: _____ **Date:** _____

Texas Health
Presbyterian Hospital
PLANO

CONSENT TO RISK OF COVID – 19 EXPOSURE AND RELEASE OF LIABILITY

I understand I am a Volunteer in an area with COVID – 19 positive or presumed positive person(s). I have been advised that there is a risk that I may be exposed to COVID – 19 as a result of my volunteering. The hospital has educated me on safety measures to minimize this risk.

I have had a chance to ask questions and have enough information to understand the risks to my health due to exposure to COVID – 19. I waive and release any and all claims against Texas Health Resources and its hospitals related to any exposure to COVID – 19 that I may have.

I certify this form has been fully explained to me, that I have read it or have had it read to me, and I understand its contents.

I agree that this Consent to Risk of COVID – 19 Exposure and Release of Liability shall be effective and binding upon me, my heirs, assigns, personal representatives, and family members. I warrant that I have the legal capacity and authority to sign this Release and Waiver of Liability.

THIS IS A LEGAL CONSENT FORM. PLEASE READ IT CAREFULY AND BE SURE YOUR QUESTIONS HAVE BEEN ANSWERED BEFORE SIGNING.

Signature of Volunteer: _____ Date: _____

Signature of parent/guardian: _____ Date: _____

Texas Health Presbyterian Hospital PLANO

JUNIOR VOLUNTEER RECOMMENDATION

As a Junior Volunteer, you are required to obtain personal recommendations from a school counselor, teacher, or adult non-family member who has worked with you in a supervisory capacity. All recommendations must be sealed and on organization's letterhead. Your application will not be accepted until this recommendation has been received.

Prospective Junior Volunteer's Name: _____

Recommendation:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of person making recommendation: _____ Title: _____

Relationship to prospective Junior Volunteer: _____

Phone Number: _____ Email: _____

Date: _____

Texas Health Presbyterian Hospital PLANO

JUNIOR VOLUNTEER RECOMMENDATION

As a Junior Volunteer, you are required to obtain personal recommendations from a school counselor, teacher, or adult non-family member who has worked with you in a supervisory capacity. All recommendations must be sealed and on organization's letterhead. Your application will not be accepted until this recommendation has been received.

Prospective Junior Volunteer's Name: _____

Recommendation:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of person making recommendation: _____ Title: _____

Relationship to prospective Junior Volunteer: _____

Phone Number: _____ Email: _____

Date: _____

Texas Health Presbyterian Hospital PLANO

Volunteer Services
Junior Volunteer Registration
***Immunization records must be submitted with application.**

Returning _____ **New** _____

Name: _____
Last **First** **Middle**

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Student Phone: _____

Parent/Guardian Phone: _____

Junior Volunteers

Emergency Contact Name: _____

Relationship: _____

Phone (H/M): _____ **Work Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Sex: _____ **M** _____ **F** **Birth Date:** _____ **Age:** _____

Social Security Number: _____

Date: _____

Texas Health Presbyterian Hospital PLANO

Health Screening Parent/Guardian Consent Form

All students must provide immunization records with Junior Volunteer Application. The required immunizations are listed below. After notification of acceptance into the program each student will be required to provide documentation of a 2 step TB skin test or a TB blood test. (TSpot or IGRA) TB test and any other required immunizations are obtained at the student's expense by their personal physician or other healthcare provider. Texas Health Plano will provide the Urine Drug Screen.

Once accepted into the program you will receive notification and specific instructions for scheduling your required appointment with Employee Health. It will be your responsibility to contact Employee Health adhering to the established deadlines bringing the following items:

- Documentation of TB Test.
- Driver's license or State ID to verify identity.
- In preparation for the Urine Drug Screening, drink no more than 24 ounces of fluid in the 3 hours prior to your appointment to prevent a dilute sample.

A parent/guardian **must** accompany student to this appointment if under the age of 18.

Student's Name _____ **Date of Birth** _____ **Social Security #** _____

Parent/Legal Guardian (if under 18) _____ **Date** _____ **Phone** _____

Mandatory Vaccines	Required Doses	Documentation Accepted
Varicella (Chickenpox)	2 doses of vaccine or lab evidence of immunity	A copy of your school immunization record, family physician's record, or other medical facility where these were given must be submitted with application.
Measles, Mumps, Rubella (MMR)	2 doses of vaccine or lab evidence of immunity	
Tetanus, Diphtheria, Pertussis (Tdap)	Most recent	
Influenza	Yearly(within 12 months during flu season)	Obtained by your personal physician or other healthcare provider.
COVID – 19	2 doses	Obtained by your personal physician or other healthcare provider
TB Test	2 Step TB Skin Test or 1 TB Blood Test—Spot/IGRA	Obtained by your personal physician or other healthcare provider.
Urine Drug Screen	16 years or older	Provided by Texas Health Plano Employee Health

Substance Abuse Screening Consent and Authorization for Release of Information for Volunteer Minors

Name: _____ ***Date of Birth:*** _____/_____/_____
Applicant SS #: _____-_____-_____
Address: _____ ***City/State/Zip:*** _____
Day Phone #: _____ ***Evening Phone #:*** _____

I hereby consent to urine, breath, saliva, and/or blood testing for the purpose of detecting the presence of alcohol and drugs, including prescription medications, controlled substances *(amphetamines, barbiturates, morphine, etc.)*, illegal drugs *(cocaine, heroin, marijuana, etc)*, and inhalants.

Volunteer Applicant: I understand per THR Human Resource guidelines that if I decline to sign this consent, and thereby decline to submit a sample for the drug test, or fail to provide a specimen within the allowable timeframe, the post-offer medical examination will not be completed and termination of the volunteer position may result.

I also understand that Employee Health Services will report my compliance or non-compliance with the THR Drug-Free Workplace Policy to the Human Resources Department. I understand that I may not obtain copies of my drug screen result.

I further consent to the release of the drug test results to the THR designated Medical Review Officer: Joseph P. Berley, M.D. I authorize the THR Medical Review Officer to verify my drug test results, to discuss medical explanations with prescribing and treating physicians and issuing pharmacists, to report results to THR and/or THR representatives, to confer with Substance Abuse Professionals and evaluating physicians, and/or to report other medical information for employment purposes. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient.

This consent and authorization is not an employment contract and does not guarantee employment or right to volunteer position. I hereby release Texas Health Resources, its employees, and agents from any and all claims, or causes of actions resulting therefrom or relating thereto.

This authorization will expire ninety (90) days from the date of my signature. I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

Date: _____ **Signature:** _____
Legally Authorized Representative (parent or guardian)

_____
Print Name

_____
Relationship to Donor

Signature of Donor: _____

Donor: I consent to discussion and disclosure of drug screen results to parent/legal guardian by Medical Review Officer.

Donor Consents to disclosure to parent/legal guardian:_____
Signature of Donor

Witness Signature: _____ Date: _____

(Witness signature must be over 18 years of age and it cannot be the same person who signs for the parent/legal guardian)

This form complies with the Privacy Information Act of 1976 and the Health Insurance Portability and Accountability Act of 1996 (HIPAA). 06/01/2022

Texas Health

Junior Volunteer Request for Medical Exemption from Vaccinations

Volunteer Name: (Print) _____ **THR Entity:** _____

Employee ID# or Last 4 of SS# _____ Department (s): _____ Position: _____

Personal Email: _____ Contact Phone Number: _____

Dear Treating Physician:

As a patient safety initiative, Texas Health Resources requires Influenza, COVID-19, MMR, Meningitis (lab personnel), Tdap, Hepatitis A (dietary), and Varicella vaccinations. These vaccinations are recommended by the CDC in the Immunization of Health Care Workers, Recommendations of the Advisory Committee on Immunization Practices (ACIP) and the Hospital Infection Control/Practices Advisory Committee (HICPAC). They have been shown in study settings to be effective in preventing the spread of disease to patients. Your patient is requesting to be exempt from one or more of these vaccinations. Medical exemption from vaccinations is allowed for recognized contraindications only. (https://www.cdc.gov/vaccines/hcp/acip-recs/general-recs/contraindications.html).

Please complete the form below to request a medical exemption for your patient. This completed form must be returned to your patient for submission.

Influenza	**My patient has the following checked contraindication(s) to Influenza (TIV-Inactivated) vaccination**: Contraindications/Precautions:

- ☐ **INDEFINITE EXEMPTION** – Documented anaphylactic reaction to a prior dose of the vaccine or any of its components (e.g., eggs)
- ☐ **INDEFINITE EXEMPTION** – Documented History of Guillian-Barre' syndrome within 6 weeks of receiving an influenza vaccine given
- ☐ **DEFERRAL** - Moderate to severe acute illness or fever, delay vaccination until: (Date Required) _____
- ☐ **DEFERRAL** - Delay vaccination until: _____ due to other medical condition: (Specify)_____

COVID 19	**My patient has the following checked contraindication(s) to COVID 19 vaccination**: Contraindications/Precautions: ☐ Pfizer ☐ Moderna ☐ Johnson & Johnson ☐ Novavax

- ☐ **INDEFINITE EXEMPTION** – Documented anaphylactic reaction to a prior dose of the vaccine or any of its components (e.g., Polyethylene glycol (PEG)
- ☐ **DEFERRAL** - Moderate to severe acute illness or fever, delay vaccination until: (Date Required) _____
- ☐ **DEFERRAL** – Recent diagnosis of COVID treated with monoclonal antibody therapy or convalescent plasma-vaccination cycle should start 90 days after treatment date: (Date Required) _____
- ☐ **DEFERRAL** - Delay vaccination until: _____ due to other medical condition*: (Specify)_____

**Active pregnancy or lactation (in the absence of other medical conditions precluding COVID-19 vaccination) are not considered to be a recognized medical contraindication*

For COVID-19, as a condition of exemption approval, volunteers may be required to wear an N95 respirator upon entering any Texas Health location.

Mumps, Measles, Rubella (MMR)	**My patient has the following checked contraindication(s) to Measles, Mumps, Measles, Rubella (MMR) Vaccination:** Contraindications/Precautions:

- ☐ **INDEFINITE EXEMPTION** –Documented Anaphylactic reaction to a prior dose of the vaccine or any of its components (e.g., gelatin, neomycin)
- ☐ **DEFERRAL** - Moderate to severe acute illness or fever, delay vaccination until: _____
- ☐ **DEFERRAL** - Untreated active tuberculosis, delay vaccination until: _____
- ☐ **DEFERRAL** - Recent administration of antibody-containing blood products, delay vaccination until: _____
- ☐ **DEFERRAL** - Immunodeficiency, delay vaccination until: _____
- ☐ **DEFERRAL** - Pregnancy, delay vaccination until: _____
- ☐ **DEFERRAL** - Thrombocytopenia/thrombocytopenic pupura (now or by history), delay vaccination until: _____

Texas Health®

Junior Volunteer Request for Medical Exemption from Vaccinations

Meningococcal (MCV)	**My patient has the following checked contraindication(s) to Meningococcal (MCV) vaccination:** Contraindications/Precautions:

- ☐ **INDEFINITE EXEMPTION** – Documented Anaphylactic reaction to a prior dose of the vaccine or any of its components.
- ☐ **INDEFINITE EXEMPTION** – History of Guillian-Barre' syndrome
- ☐ **DEFERRAL** - Moderate to severe acute illness or fever, delay vaccination until: _____

Tetanus Diphtheria Pertussis (Tdap)	**My patient has the following checked contraindication(s) to Tetanus Diphtheria acellular Pertussis (Tdap) acellular vaccination:** Contraindications/Precautions:

- ☐ **INDEFINITE EXEMPTION** – Documented Anaphylactic reaction to a prior dose of the vaccine or any of its components.
- ☐ **INDEFINITE EXEMPTION** – History of Guillian-Barre' syndrome within 6 weeks of receiving an influenza vaccine given <10 years ago.
- ☐ **INDEFINITE EXEMPTION** – Encephalopathy within 7 days of previous dose of DTaP or DTP (use Td instead of Tdap)
- ☐ **INDEFINITE EXEMPTION** – History of Arthus reaction following a previous dose of a tetanus-containing and/or diphtheria toxoid-containing vaccine, including meningococcal conjugate vaccine giver < 10 years ago.
- ☐ **DEFERRAL** -Pregnancy (1st trimester), delay vaccination until: _____
- ☐ **DEFERRAL** - Moderate to severe acute illness or fever, delay vaccination until: _____

Varicella (Chickenpox)	**My patient has the following checked contraindication(s) to Varicella (Chicken pox) vaccination:** Contraindications/Precautions:

- ☐ **INDEFINITE EXEMPTION -** Anaphylactic reaction to a prior dose of the vaccine or any of its components (e.g., gelatin, neomycin)
- ☐ **DEFERRAL -** Moderate to severe acute illness or fever, delay vaccination unit: _____
- ☐ **DEFERRAL -** Recent administration of antibody containing blood products, delay vaccination until: _____
- ☐ **DEFERRAL -** Immunodeficiency, delay vaccination until: _____
- ☐ **DEFERRAL** - Pregnancy, delay vaccination until: _____

Request for medical exemption from vaccination will be reviewed by the Accommodation Review Committee. Further clarification and/or additional supporting documentation may be requested.

I certify the above information is true and correct regarding the request for medical exemption for my patient from the vaccination(s) selected above:

Print Physician/Advance Practice Provider Name: _____ Phone #: _____

Physician /Advance Practice Provider Signature: _____ Date: _____

(Signature stamp is not acceptable)

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I _____ understand that my medical information is confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. The above information may be released to the Comprehensive Immunization Policy Vaccination Exemption Committee to validate medical vaccination exemption. ***Exemption requests other than "INDEFINITE" must be resubmitted annually. Electronic ReadySet surveys MUST be completed annually.***

Volunteer Signature: _____

(Signature required prior to submitting for review)

Parent/Guardian Signature: _____

Date: _____

Texas Health

Request for Religious Exemption from Vaccinations

I _____ (Print Full Name) affirm that vaccination and injections of immunizing agents conflicts with my religious tenets or practices.

I confirm I have read and understand THR's policy on required vaccinations and will adhere to the masking and testing requirements* as applies to my work environment should my exemption request be approved. Texas Health, Employee Health staff will review this request for exemption and then submit for review by the Accommodation Review Committee.

Requesting exemption from:

☐ Influenza ☐ TDAP ☐ MMR ☐ Varicella ☐ Meningitis ☐ COVID-19*

**For COVID-19, as a condition of exemption approval, employees will be required to wear an N95 respirator upon entering any Texas Health location and must complete required PCR COVID testing.*

Please provide a statement of your request with ***SPECIFIC religious*** reasons for requesting this exemption. Specifically describe the conflict between your religious belief, observance or practice and the vaccine requirement at issue (You may attach additional pages)

_____

_____

_____

_____

_____

_____

Have you received immunizations in the past? **Yes** or **No** (circle one)

If yes to the previous question, please provide an explanation detailing any changes in your religion, belief or observance that have occurred since your last immunization, or the reason(s) that your religion, belief or observance prevents you from receiving the vaccine(s) indicated above specifically:

_____

_____

_____

By my signature below I am affirming this information to be true and acknowledge that any false or intentionally misleading statements or omissions on this document may be considered as sufficient cause for progressive corrective action up to and including termination. This may occur even if such false statement or omission is discovered subsequent to an exemption from the THR vaccination requirements is granted. I also understand that THR may seek clarification and/or request additional supporting documents regarding this request.

Date: _____

Employee/Physician/Volunteer Signature: _____

Current Phone #: _____ Employee ID (or last 4 of SS#): _____

Employee Entity Location: _____ Department(s): _____ Position: _____

Personal Email Address: _____

Texas Health Presbyterian Hospital PLANO

Junior Volunteer Forms to Be Returned

Complete and Return by March 27th deadline.

This packet includes required paperwork/forms to begin the junior volunteer process and our partnership. Make certain that all forms are completed and signed prior to returning. Make sure all required pages are included. Incomplete applications will not be considered.

- Recent picture (no larger than passport size---2x2)
- Junior Volunteer Application (3pages)
- Manual Order-Background Check Application (2 pages)
- Social Security number **must** be included
- Background Check Authorization (1 page)
- Background Check Disclosure (1 page)
- Volunteer Agreement (1 page)
- Volunteer Business Associate & Confidentiality Agreement (1 page)
- Consent to be Photographed, Filmed Videotaped/Interviewed (1 page)
- Consent to Risk of Covid-19 Exposure (1 page)
- Junior Volunteer Recommendations (2 pages)
- Volunteer Services Junior Volunteer Registration (1 page)
- Copy of immunization records
- Health Screening Parent/Guardian Consent Form (1 page)
- Substance Abuse Screening Consent & Authorization (1 page)
- Junior Volunteer Request for Medical Exemption (2 pages)
- Junior Volunteer Request for Religious Exemption (1 page)