



1324 LAKELAND HILLS BLVD

LAKELAND, FL 33805

PO BOX 95448

LAKELAND, FL 33804-5448

863.687.1100 + myLRH.org

Dear Student,

Thank you for your interest in the Lakeland Regional Health Teen Volunteer Program. Attached are several documents that must be completed in their entirety before returning to Volunteer Services by:

**Friday, March 13, 2026**

**THE PROGRAM WILL NOT TAKE INCOMPLETE PACKETS**

This may be your first exposure to the field of patient care services, and we want to keep everyone well informed, enthusiastic and interested in their volunteer experience. We encourage you to continue to participate throughout your school years and perhaps pursue medical careers upon graduation.

**Please keep the first 4 pages of this packet for your reference. You can either email the completed application with the requested paperwork to [Darcy.King@mylrh.org](mailto:Darcy.King@mylrh.org) or mail the packet to:**

Lakeland Regional Health Volunteer Services  
PO Box 95448  
Lakeland, FL 33804

The following are requirements that everyone needs to meet before participating in the Teen Volunteer Program:

1. All high school students must be at least 15 years of age by June 1, 2026.
2. Completed application.
3. Completed and notarized parental consent form.
4. Copy of your up-to-date immunization record. This must include proof of two (2) Measles/Mumps/Rubella (MMR) Vaccinations, Chicken Pox Vaccination or proof of having Chicken Pox (Varicella).
5. Results from a TB test that must be completed within the past three (3) months of application submission. This can be obtained from your Pediatrician, Health Department, or a participating Pharmacy.
6. Completed TB Questionnaire.
7. Letter of recommendation from your school's guidance counselor, teacher, administrator, Scout leader, employer, or another adult not related to you and not living in your house.
8. All students that submit a completed application will receive an email with information on how to schedule a face-to-face 15-minute interview. Interviews will begin the week of March 16<sup>th</sup> and it will be the student's responsibility to call to make that appointment upon receipt of the email.

This Summer, the Teen Volunteer Program will begin on Monday, June 1, 2026 (Teen Volunteer Orientation), with an end date of Saturday, August 1, 2026.

Please feel free to contact me at 863.687.1115 should you have any questions regarding this process.

Sincerely,

Darcy King, MSML  
Manager of Volunteer & Concierge Services

# Welcome to the Lakeland Regional Health Teen Volunteer Program

As a member of our Teen Volunteer Program, you will find a personal satisfaction in serving the hospital and our patients as you offer your time and talents. You will have the opportunity to acquaint yourself with a variety of health careers in addition to learning new skills.

Remember, as a Teen Volunteer, you agree to the following commitment - **I Will Be:**

## **DEPENDABLE:**

- I will be on time for duty. If I am unable to report for duty, I will notify the Supervisor that I have been assigned to. I will notify my Supervisor or the Volunteer Manager in advance of vacation or other scheduled absences.

## **COOPERATIVE:**

- I will only complete the service I am assigned. If I would like to change services, I will discuss this with the Volunteer Manager.

## **RESPONSIBLE:**

- I will wear my name badge at all times - only on the upper right side.
- I will not bring valuables with me.
- I will report any accidents or incidents while on duty to my Supervisor and the Volunteer Manager.
- I will only go to areas of the hospital that are assigned to me.

## **QUIET:**

- I will walk quietly in the hallways.
- I will talk quietly in the hallways and when I walk into any rooms in the hospital or campuses.

## **PLEASANT AND COURTEOUS:**

- I will remember that I am part of the patient care team and thus contribute to the impression others have of **Lakeland Regional Health**.

## **WILLING:**

- I will be a willing Teen Volunteer, remaining flexible to serve where needed.

## **REMEMBERING:**

- I will remember that I am a teenager working in the adult world of medical science.
- As a Teen Volunteer, I must observe the same professional ethics as the LRH team members (employees). To the public, I appear as a professional, therefore, I must act in a professional manner at all times.



## I WILL NOT:

- Sit on a patient's bed.
- Make personal telephone calls, text, or take photos while on duty. *Cell phones will remain off for the duration of your shifts unless you are on break.*
- Visit with friends while on duty.
- Bring guests to work with me.
- Use perfume, highly scented powder, cologne or after shave lotion.
- Wear conspicuous make-up or excessive jewelry. *All visible pierced body jewelry other than earrings must be removed (i.e. eyebrow or nose rings).*
- Wear gel nail polish or acrylic nails (department specific). Other painted nails must be neat and unchipped.
- Wear fake eyelashes nor acrylic nails.
- Chew gum, eat or drink in front of patients or visitors in departments, or smoke while on duty. (All Lakeland Regional Health campuses are smoke-free.)
- Sit in or ride in wheelchairs.
- Play on the elevators.
- Accept tips.
- Run in the hallways or anywhere in the hospital.

## MEALS:

You will receive a meal credit worth \$12.00 for your use on the days you are volunteering. Volunteers are responsible for charges above \$12.00. **Do not** take your breakfast, lunch, or dinner break during your 4-hour shift. (Those who choose an 8-hour shift will have a 30-minute lunch break during their shift.) Please arrange to enjoy your meal before or after your shift and during a convenient period for the service area where you volunteer. Always let your Supervisor know when you are leaving.

## UNIFORM:

Teen Volunteers are **required** to wear the uniform that consists of a LRH polo shirt and khaki pants. The cost of the polo shirt is \$20, and will be available for purchase during Orientation. Only closed toe and closed heel shoes are permitted, including sneakers of any color. No shorts, skorts, nor any pants made of denim fabric are allowed. Capri pants are allowed for females as long as they are not more than 4 inches above the ankle.

You will be sent home if you are not wearing your uniform. Please note you will be released from service if you report for duty not wearing the required uniform for the second time.

## SERVICE HOUR REPORTS:

If you do not clock in or clock out, you will not be given credit for your volunteer hours unless you contact the Volunteer Manager immediately to correct the error. You are held responsible for keeping track of your daily hours which is a requirement from your

school using the Community Service form. You can pick up this form at the school guidance counselor's office.

Remember, only the Manager of Volunteer Services can sign your Community Service forms.

**DISMISSAL FROM PROGRAM:**

At LRH, our primary concern is our patients. Any Teen Volunteers who show disregard for LRH/Hospital Policies and are not respectful to others will be dismissed from service.

**PATIENT CONFIDENTIALITY:**

LRH Health System/Hospital Policy and Federal regulations require all patient information to be kept confidential. Volunteers who breach patient confidentiality will be terminated immediately.

**MANDATORY TUBERCULOSIS (TB) SKIN TEST:**

The TB must be administered by your Pediatrician, Health Department, or participating pharmacy and the results attached with your application submission. The included TB Questionnaire must also be completed.

# TEEN VOLUNTEER APPLICATION



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**PART I:** Please complete the application in its entirety. Print neatly.

Date: \_\_\_\_\_

NAME:

First Name \_\_\_\_\_ Middle \_\_\_\_\_ Last Name \_\_\_\_\_

Address: \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone: Home ( ) \_\_\_\_\_ Cell ( ) \_\_\_\_\_

E-Mail Address: \_\_\_\_\_ (Please Print)

School: \_\_\_\_\_ Current Grade: \_\_\_\_\_

Social Security Number: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

IN CASE OF AN EMERGENCY INVOLVING THIS TEENAGER WHILE ON DUTY YOU MAY CONTACT THE FOLLOWING INDIVIDUALS IF PARENT/GUARDIAN IS NOT AVAILABLE

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

I hereby state that my son/daughter is at least 15 years old by June 1st, and I give my consent for him/her to serve as a volunteer in the Teen Volunteer Summer Program. He/she understands that breach of patient confidentiality will be cause for immediate termination for the program.

Parent's Signature

Applicant's Signature



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**Part II:** Please respond to the question below.

**WHY DO YOU WANT TO PARTICIPATE IN Lakeland Regional Health's TEEN VOLUNTEER SUMMER PROGRAM?  
(Must be completed, and please be specific as to why you want to be part of this program)**



## Teen Program | Parental Consent Form

I understand that my child, \_\_\_\_\_ (print name of child) who is under eighteen (18) years of age and unmarried, has applied for membership as a Teen Volunteer at Lakeland Regional Health (LRH). I am aware that before serving as a Teen Volunteer, the following documentation or certified proof of laboratory test results must be obtained from the Public Health Department or my child's Pediatrician and provided to the Volunteer Manager:

1. Documentation of receipt of two (2) doses of MMR vaccine on or after twelve (12) months of age or laboratory evidence of Rubella (German Measles) and Rubella (Measles) immunity, as well as the Varicella Vaccinations.
2. Documentation of negative Tuberculosis (TB) skin test within the past three (3) months or if TB skin test is positive, documentation of negative chest x-ray within the past two (2) months along with a clearance letter from your Pediatrician.

In the event my child is injured or becomes ill while at LRH, I hereby authorize LRH and its personnel to provide appropriate medical care or treatment to my child, as they deem necessary or advisable.

I acknowledge that I have read this consent form in its entirety and understand fully its contents and voluntarily execute it realizing what I am doing by signing it. I further acknowledge that all my questions have been answered to my satisfaction and I have proper legal custody of my child named above.

This consent form must be signed in the presence of a Notary Public.

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Parent or Legal Guardian - Signature

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Parent or Legal Guardian - Printed

State of Florida

County of \_\_\_\_\_

The foregoing Teen Volunteer Parental Consent form was acknowledged before me this \_\_\_\_\_ day of \_\_\_\_\_ 2026, by \_\_\_\_\_ (name of parent or guardian) who is personally known to me or who has produced \_\_\_\_\_ (type of identification).

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Notary Signature

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Notary Printed Name

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Commission Number & Expiration Date



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## Volunteer Services

**RECOMMENDATION FORM:** Please return this form to the teen applicant. If you have any questions or concerns, please call the Volunteer Manager at 863.687.1115.

**TO THE APPLICANT:**

At Lakeland Regional Health, our primary concern is for our patients and their families. It is imperative that all who enter service as a Volunteer appreciate the importance of respecting the rules and structures that govern us. Adult and Teen Volunteers are required to comply with specific regulations to protect the safety and privacy of our patients. We ask for this letter of recommendation from a teacher, counselor, Scout leader, employer, or other adult not related to you and not living in the same household, who can speak of your character and reliability and give us the confidence necessary to include you in our Program.

(Print applicant's Name) is applying for the LRH Teen Volunteer Program.

## TO THE EVALUATOR:

In order to assist us in evaluating the applicant above for admission to the Lakeland Regional Health Teen Volunteer Program, we would appreciate your responses to the following questions. Comments, which may be viewed as other than positive, will not necessarily preclude a student's admission to the program.

1. Please comment on the character, attitude and emotional maturity of the applicant.



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**Recommendation form continues >**

2. Does this student have the ability to work in an unsupervised situation?

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3. To your knowledge, has the student had any disciplinary problems?

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4. Please comment on the strengths that you feel this student possesses.

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5. Please add any additional comments that you feel would be of assistance to the student or to the Volunteer Manager.

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Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_ Position/Title: \_\_\_\_\_

Organization/School: \_\_\_\_\_

Daytime phone: \_\_\_\_\_

# LRH TB QUESTIONNAIRE

## Annual review - New Hires – Students - **Volunteers**

Name \_\_\_\_\_ Date \_\_\_\_\_

			YES	NO	DON'T KNOW
1.	Have you been tested for TB within the last 6 months?		Y	N	DK
	If yes, circle type: TST (PPD skin test) or IGRA (Blood test – QuantiFERON or T-Spot)				
	Date of test:		Result:		
2.	In the past year, have you had any of the following symptoms?				
	Coughing up blood (hemoptysis):		Y	N	DK
	Hoarseness lasting 3 or more weeks:		Y	N	DK
	Persistent cough lasting 3 or more weeks:		Y	N	DK
	Unexplained excessive fatigue:		Y	N	DK
	Unexplained persistent fever lasting 3 or more weeks:		Y	N	DK
	Unexplained excessive sweating at night:		Y	N	DK
	Unexplained weight loss:		Y	N	DK
3.	Since your last TB test have you...				
	Been notified of a potential TB exposure?		Y	N	DK
	Traveled out of the country?		Y	N	DK
	List countries:				
	Visited any jails, prisons, or detention centers anywhere for any reason?		Y	N	DK
4.	Have you had a chest X-ray within the last year?				
	If yes: Date: Result:				
5.	Have you ever been told by a health care provider that you have TB?				
	If yes, were you treated?		Y	N	DK
6.	Have you ever been told you have latent TB (LTBI)?				
	If yes, were you treated?		Y	N	DK
7.	Have you ever received the BCG vaccine?				
8.	Have you been told that you are immunocompromised or cannot fight infection?				
9.	Have you had pneumonia within the last year?				
10.	Have you ever lived or had close contact with someone who has/had active TB?				
11.	Have you ever been told you have an abnormal chest x-ray?				
12.	Have you ever worked where patients with active TB receive care or services?				
13.	Were you born within the US?				
	If not, name country:				
14.	Comments:				

Signature \_\_\_\_\_