

Dear Student,

Thank you for your interest in the Lakeland Regional Health Teen Learning Program. Attached are several documents that must be completed in their entirety before they are returned to my attention.

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 teen learning experience. We encourage you to continue to participate throughout your school years and perhaps pursue medical careers upon graduation.

Please keep the first 2 pages of this packet for your reference. You can either email the completed application with the requested paperwork to Darcy.King@mylrh.org or mail the packet to:

Lakeland Regional Health
Attn: Darcy King, Manager of Volunteer & Teen Learning Programs
PO Box 95448
Lakeland, FL 33804

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

1. All high school students must be at least 15 years of age to be eligible.
2. Completed and signed application.
3. Completed and notarized parental consent form.
4. The following three items are required from your Pediatrician's office:
 - a. Copy of your up-to-date immunization record. This must include proof of two (2) Measles/Mumps/Rubella (MMR) Vaccinations, Chicken Pox Vaccinations or proof of having Chicken Pox (Varicella).
 - b. Results from a TB test that must be completed within the past three (3) months (available from your Pediatrician, Health Department, or participating Pharmacy).
 - i. The TB Questionnaire in this packet must also be completed.
 - c. During flu season (mid-November through end of March), proof of a flu vaccine is required.
5. Completed 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 household.
6. All students that submit a completed application will receive an email with information on scheduling an interview.

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

Sincerely,

Darcy King, MSML
Manager of Volunteer & Teen Learning Programs

Teen Learning Program

Things to Know

MEALS:

You will receive a meal credit worth \$12.00 for your use on the days you are volunteering. You are responsible for any charges above \$12.00. Do not take your breakfast, lunch, or dinner break during your shift; please arrange to enjoy your meal before or after your shift. Always let your Supervisor know when you are leaving.

UNIFORM:

You 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. You must wear closed toe and closed heel shoes and they can be 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.

SERVICE HOUR REPORTS:

Please ensure to pick up your Community Service Hours form or Bright Futures form from your school. Only the Manager of Volunteer & Teen Learning Programs can approve and sign your forms.

MANDATORY TUBERCULOSIS (TB) TEST:

The TB test must be administered by your Pediatrician, Health Department, or participating pharmacy and the results attached with your application submission, and we will accept results from a skin test or a lab draw.





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TEEN LEARNING PROGRAM APPLICATION

1324 Lakeland Hills Blvd • P.O. Box 95448 • Lakeland, FL 33804 • 863.687.1115

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

Date: _____

NAME:

First Name

Preferred First Name (if applicable)

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, and I give my consent for him/her to serve in the Teen Learning Program. He/she understands that breach of patient confidentiality will be cause for immediate termination from this 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 LEARNNG PROGRAM? (Must be completed, and please be specific as to why you want to be part of this team.)

This image shows a blank sheet of white paper with horizontal ruling lines. The lines are evenly spaced and run across the width of the page. There are no margins, text, or other markings on the paper.



Lakeland Regional Health®

Teen Learning 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 in the Teen Learning Program at Lakeland Regional Health (LRH). I am aware that before serving as a Teen Member, the following documentation and proof of laboratory test results must be obtained from the Public Health Department, my child's Pediatrician, or participating pharmacy:

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.

Parent or Legal Guardian - Signature

Parent or Legal Guardian - Printed

State of Florida

County of _____

The foregoing Teen Learning Program Parental Consent form was acknowledged before me this _____ day of _____ 202____, by _____ (name of parent or guardian) who is personally known to me or who has produced _____ (type of identification).

Notary Signature

Notary Printed Name

Commission Number & Expiration Date



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Teen Learning Program

RECOMMENDATION FORM: Please return this form to the teen applicant. If you have any questions or concerns, please call Darcy King, Manager of Volunteer & Teen Learning Programs 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 in the Teen Learning Program appreciate the importance of respecting the rules and structures that govern us. Adult and Teens alike 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 the student and not living in the same household, who can speak of the student's character and reliability and give us the confidence necessary to include them in our Program.

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

TO THE EVALUATOR:

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

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

Recommendation form continues >

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

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

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

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

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?	Y	N	DK
	If yes: Date: _____ Result: _____			
5.	Have you ever been told by a health care provider that you have TB?	Y	N	DK
	If yes, were you treated?	Y	N	DK
6.	Have you ever been told you have latent TB (LTBI)?	Y	N	DK
	If yes, were you treated?	Y	N	DK
7.	Have you ever received the BCG vaccine?	Y	N	DK
8.	Have you been told that you are immunocompromised or cannot fight infection?	Y	N	DK
9.	Have you had pneumonia within the last year?	Y	N	DK
10.	Have you ever lived or had close contact with someone who has/had active TB?	Y	N	DK
11.	Have you ever been told you have an abnormal chest x-ray?	Y	N	DK
12.	Have you ever worked where patients with active TB receive care or services?	Y	N	DK
13.	Were you born within the US?	Y	N	DK
	If not, name country: _____			
14.	Comments:			

Signature_____