ARROWHEAD REGIONAL MEDICAL CENTER
Department of Volunteer Management
Parental/Guardian Consent Form

I hereby give permission for my child _____ to serve in a volunteer capacity at Arrowhead Regional Medical Center, if accepted by the agency. I understand my child will be expected to meet all the requirements of the position, including regular attendance and adherence to applicable Medical Center policies and procedures. I understand they will not receive monetary compensation for the services contributed. All volunteer positions serve at the pleasure of the County Medical Center and may be terminated at any time without cause.

Should my child become ill or be injured while volunteering, I authorize the Medical Center, its employees, and physicians to provide medical treatment as indicated, if I cannot be notified. I will be financially responsible for costs incurred for all treatment.

I understand that my child must obtain health clearance before beginning their volunteer assignment. If I am unable to provide documentation to meet health clearance requirements, I authorize Arrowhead Regional Medical Center to perform the following procedures, if indicated, on my child at no cost to me:

- Screening test(s) for Tuberculosis (Mantoux/Chest X-ray).
- Blood test to determine immunity to Measles, Mumps, Rubella and/or Varicella.
- Vaccination for Measles Mumps, Rubella and/or Varicella if my child is not immune.
- Vaccination with Tdap (Tetanus, Diphtheria, Pertussis)
- Annual flu vaccination (October-March)
- If applicable, I also authorize the Medical Center, its physicians and employees to administer a series of vaccinations for Hepatitis B and perform post-vaccination serology testing.
- Other screening and/or immunization deemed necessary as the situation arises may be undertaken on the advice of the Infection Control Chairman and Hospital Administration.

Child's Name: _____

Health Insurance Information: Company name _____

Group # _____

Subscriber # _____

Name of person carrying insurance: _____

I have had an opportunity to ask questions regarding all aspects of my child's participation in the volunteer program at Arrowhead Regional Medical Center and have had any questions answered to my satisfaction.

_____ _____
Parent/Guardian's Name (Printed) Signature of Parent/Legal Guardian

_____ _____
Relationship to Volunteer Date Signed

Rev. 3/23/21~ TEENAPPL.doc