United HOSPICE
When time matters most

Youth for Hospice Volunteer Application

Name: _____ **Date:** _____

Home phone: _____ **Cell phone:** _____

Email: _____

Home address: _____

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

Birthdate: _____

School: _____ **Graduation year:** _____

In case of emergency:

Notify: _____ **Relationship:** _____ **Phone:** _____

Please submit this form to
Greg Essenpreis, Patient Experience Program Director
11 Stokum Lane, New City, NY 10956
gessenpreis@unitedhospiceinc.org
P: 845-634-4974
F: 845-634-7549

UNITED HOSPICE, INC.
Parent/Guardian Consent Form Continues Below
For Hospice Volunteers (minors) of United Hospice, Inc.

This consent form is provided to the parents/guardians of volunteers under the age of 18. As the parent/guardian, you play an important role in your child's experience as a hospice volunteer. This form is intended to inform you of policies and procedures. We ask that you read this with your child and sign the statements below, indicating understanding and acceptance.

- All patient information that your child may encounter in the course of his/her work is to be kept confidential as required by Federal Privacy Laws. Your child will sign a statement of confidentiality and understand the Health Insurance Portability and Accountability Act.
- Your child is to document all hours given in service to the agency via email or on the Volunteer Time Sheet. This is necessary to enable United Hospice to fulfill our Federal mandate to utilize volunteers, and to make it possible for us to document the teen's contribution should documentation be needed as proof of community service hours.

I hereby give consent for my child, _____,
to participate as volunteer for United Hospice, Inc. (UH). I agree to release and hold harmless UH, its board of directors, officers, employees and representatives from any and all liability of any kind or nature whatsoever in connection with any injury, loss, damage, or expense suffered or incurred by the above-named youth volunteer as a result of an act or failure to act, intentional or unintentional, related to their volunteer activity.

In the event of a medical emergency, I understand that emergency medical treatment will be sought for my child. If an effort to reach the parent or guardian is not successful, I also authorize the adult agents, officers, employees or representatives of UH to consent to any X-ray examination, anesthetic, medical or surgical diagnosis/treatment and hospital care.

I hereby consent to the use of my/my child's name, likeness, and speech in any audio tape, video tape, film or photograph made by or on behalf of UH for business or publicity purposes. I understand that any participation offers no remuneration and that my child's name, likeness and speech may be edited, produced, recorded for duplication. I expressly release United Hospice, its directors, officers, employees, representatives, licensees, assignees, affiliates and successors from any privacy, defamation, or other claims I may have arising out of broadcast, exhibition, publication, or promotion of this program.

The undersigned has read, understood and freely and voluntarily agreed to the terms and conditions of this agreement as outlined.

Print Parent/Guardian Name:_____

Signature of Parent/Guardian, Date:_____

Emergency Contact Information:_____

Parent/Guardian email: _____