



Dear Prospective Volunteer,

Thank you for your interest in the Volunteer Program. Being a Volunteer is a very rewarding experience. In addition to the satisfaction you receive from helping others, you will also gain insights into the medical field as a possible profession.

To be a Volunteer, you must:

1. Be 14-18 years old
2. Complete the application containing your signature and that of a parent or guardian
3. List two (2) personal references (individuals who are over 18 years old and not a member of your immediate family)
4. Attend the general orientation session on Tuesday, June 9, 11:30am-3:30pm at the hospital
5. Complete the health history form
6. Must be in good academic standing in school
7. Accept your assignment in good faith and be present when scheduled or arrange for a replacement; volunteering is a commitment

You will receive a letter with details prior to the general orientation. If you have any questions, please contact Sarah Osegard at 715-284-3606 or email osegards@blackriverhealth.com.

We look forward to meeting you!
Sincerely,

Sarah Osegard
Volunteer Coordinator

Please return the completed application packet (application, permission form, personal release, and health record) by May 15, 2026 to:

Black River Health
Attn: Sarah Osegard
711 West Adams Street
Black River Falls, WI 54615

Date: _____

I hereby give permission for my child, (name) _____, to participate in the Volunteen Program at Black River Health (BRH). I certify that my child is _____ years of age and that his/her birthdate is _____.

I authorize any health screening that is required for participation in the Volunteen Program.

I understand that as a Volunteen, my child is making a commitment to Black River Health. He/she has an obligation to carry out the responsibilities he/she undertakes. I will take part in this commitment by assuring that he/she will report on time for assignments. I will also make sure notice is given when he/she cannot be there at the scheduled time.

To volunteer at Black River Health, my child will attend the general orientation session on Tuesday, June 9, 2026, 11:30am-3:30pm at the hospital.

My child will return the permission forms, personal release, and health record by June 4, 2026.

Parent/Guardian Signature: _____

Home Phone: _____

Work Phone: _____

Cell Phone: _____



CONSENT TO PHOTOGRAPH, INTERVIEW, AND/OR VIDEO

I hereby consent **Black River Health, Inc.** and its agents, staff, and representatives to make, use, edit, reproduce, and publish any of the following (strike if not applicable): photographs, video, verbal comments, written comments, recorded interview, and other audiovisual records of me. I consent to and authorize the use of these items in the following manner (strike if not applicable): internal publications, community or public announcements, internet/website, email, social media, release to the media, and patient and medical professional education. This consent shall act to expressly release from liability Black River Health, Inc., any and all of its staff, its agents, representatives, consultants, and physicians.

Name (printed): _____

Address: _____
Street Address

_____ City State Zip

I am over 18 years of age: Yes No* Phone: _____

Signature of above-named person Date

Witness Signature Date

*If the above-named person is under 18 years of age or is otherwise unable to consent, consent should be given by parent or guardian as follows:

I hereby certify that I am the parent/guardian of: _____

This person is unable to consent because: _____

For the above-named person, I do hereby give my consent and authorization to the foregoing on behalf of him/her/them.

Signature of parent/guardian Date

Signature of witness Date

Name: _____

Phone: _____

Address: _____
Street City State Zip

Emergency Contact Name: _____

Phone: _____

Date of Birth: _____

ALLERGIES Food – Please specify: _____ Medications – Please specify: _____ Latex

Describe your reaction(s) to the items listed above: _____

CHILDHOOD ILLNESSES

Have you ever had any of the following illnesses?

 Measles Rubella (German Measles) Whooping Cough Scarlet Fever Polio Mumps Shingles Other: _____**IMMUNIZATIONS**

Provide the dates of when you received the following immunizations, TB testing, or immune titer records. If records are not available, a blood draw will be performed, at no cost to you, to determine immunity status.

Measles MMR: 1) _____ 2) _____ OR Titer Results: _____

Mumps MMR: 1) _____ 2) _____ OR Titer Results: _____

Rubella MMR: 1) _____ 2) _____ OR Titer Results: _____

Varicella/Chicken Pox Status: _____ OR Titer Results: _____

Hepatitis B Status: _____

Tetanus Date: _____ Tdap or Td
Optional

To the best of my knowledge, I am free from contagious disease and know of no condition which would prevent me from performing volunteer activities. I further consent to pre-service laboratory testing and vaccination, if indicated.

Signature: _____

Date: _____