Weisman Children's
Rehabilitation Hospital · Outpatient · Medical Day Care

STUDENT OBSERVATION APPLICATION

LAST/FIRST NAME: _____ D.O.B.: _____ SEX: M ____ F ____

HOME ADDRESS: _____CITY/STATE/ZIP:_____

HOME #: _____ CELL #: _____ EMAIL: _____

BEST WAY TO REACH YOU? CIRCLE ONE: CELL HOME EMAIL TEXT

EMERGENCY CONTACT/NUMBER: _____RELATIONSHIP: _____

EDUCATION HISTORY: Circle the Year Completed

High School 9 10 11 12 **College** 1 2 3 4 **Post-graduate** 1 2 3 4

Name of High School_____ City/State_____

Major_____ Degree/Licensure/Certification_____

Major_____ Degree/Licensure/Certification_____

Current School_____ City/State_____ Year_____

DISCIPLINE OF INTEREST: Circle Your Placement of Choice

*Speech Therapy (ST) * Occupational Therapy (OT) *Physical Therapy (PT)
* Therapeutic Recreation (TR) *Other: _____

Are You Pursuing An Opportunity with Weisman To Satisfy A Course/Program Requirement?
Yes ____ No ___

How Many Supervised Hours Are You Hoping To Gain? _____

AVAILABILITY: List Days & Blocks of Time (ST/PT/OT placements are Mon-Friday & TR are Mon-Sunday).

_____

_____

Are you fluent in any languages besides English (including American Sign Language)? If so, please list: _____

_____

Please Explain You're Interest In WCRH For Your Observation Placement. What Do You Hope To Gain From Your Experience?

_____

_____

_____

_____

ADDITIONAL QUESTIONS:

Are There Any Health Concerns or Accommodations Required That Could Affect Your Observation Time?
Yes ____ No _____
If Yes, Please Explain:

_____

Have you ever been convicted of a law violation (excluding traffic violations)? Yes ____ No _____

If yes, explain: _____

Which location would you prefer: Marlton____ Pennsauken____ Washington Twp____ Northfield ____

STATEMENT OF UNDERSTANDING

- I certify that all statements made in this application are true to the best of my knowledge.
- I understand that Weisman Children's Rehabilitation Hospital reserves the right to accept or reject my application in its sole discretion.
- I understand that I must provide any documentation that is required and is to be completed by hospital staff member(s) at the time of observation.

For Individuals Spending More Than 1 Day at WCRH

- I understand that I will be required to have a recent health screening and examination.
- I understand that I will be required to present copies of my immunization records & written verification from my personal physician of:

A.) Two MMR vaccines (measles, mumps, and rubella) OR

B.) Titers for each disease and verification of immunity to the chicken pox disease

- I understand that I will be required to have a current PPD.

By signing my name below, I agree to the above and understand that any misrepresentation, falsification, misleading statements or omission of facts made by me may result in my disqualification from further consideration for volunteering at WCRH.

_____ _____
Signature of Applicant Date

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Date	Time in	Time out	Total time	Therapist signature

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Volunteer Health Examination and Immunization Record

Name: _____ Date of Birth _____

Vital Signs T_____ P_____ R_____ BP Height _____ Weight _____

Immunization Record –Please attach copy of record or titers. Titers are only drawn if there is no record of immunizations. If Titers are required the cost is the responsibility of the volunteer.

Rubella (German Measles)(2 dates)
History of the disease: Yes / No (circle)
Date vaccine was administered: _____/_____
Blood Titer: _____ Date Immune Non Immune Non Definitive (circle)

Rubeola (Measles) (2 dates) (exempt if born before 1957)
History of the disease: Yes / No (circle)
Date vaccine was administered: _____/_____
Blood Titer: _____ Date Immune Non Immune Non Definitive (circle)

Varicella (Chicken Pox) (2 dates)
Physician documented history of the chicken pox- varicella titer is not required.:
Yes / No (circle) Date vaccine was administered:_____/_____
Blood Titer: _____ Date Immune Non Immune Non Definitive (circle)

Hepatitis B immunity not required.
History of the disease: Yes / No (circle)
Date's vaccine was administered #1_____ #2_____ #3_____
Blood Titer: _____ Date Immune Non Immune Non Definitive (circle)

Tuberculosis Screening: (PPD required within the year.)

Date given: _____ Date read: _____

Volunteer qualifications: I have examined the above individual and have found him/her to be in good mental and physical health and in my opinion has no condition that would prevent him/her from performing the duties as a student observer.

_____ _____
Physician /Healthcare Name Phone #

_____ _____
Signature Date

_____ _____
Volunteer Signature Date

_____ _____ _____
Parent/Legal Guardian Signature (relationship) Date office stamp

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Volunteer Medical Questionnaire

Name of Applicant _____

Do you have or have you ever had:	**Details:**
1. A back injury? _____	_____
2. A herniated disc in your back? _____	_____
3. Back surgery for removal of a disc? _____	_____
4. A neck injury? _____	_____
5. A herniated disc in your neck? _____	_____
6. Neck surgery for the removal of a disc? _____	_____
7. Knee injury? _____ Which knee?_____	_____
8. Knee Surgery? _____ Which knee? _____	_____
9. Shoulder injury? _____ Which shoulder? _____	_____
10. Shoulder surgery?_____ Which shoulder?_____	_____
11. Elbow injury? _____ Which elbow? _____	_____
12. Elbow surgery?___ Which elbow?_____	_____
13. Wrist injury? _____ Which wrist? _____	_____
14. Wrist surgery?_____ Which wrist?_____	_____
15. A hernia?_____ Which side? _____ Surgery? _____	_____
16. Arthritis or rheumatism? _____	_____
17. Amputation of a digit or extremity? _____	_____
18. Epilepsy? _____	_____
19. Diabetes? _____	_____
20. Cardiac disease/high blood pressure? _____	_____
21. Respiratory Problems? _____	_____
22. Tuberculosis? _____	_____
23. Total loss of sight in one or both eyes or a partial loss of corrected vision of more than 75% bilaterally? _____ Which eye?_____	_____
24. Residual disability from poliomyelitis (polio)? ___	_____
25. Cerebral Palsy? _____	_____
26. Multiple Sclerosis? _____	_____
27. Parkinson's Disease? _____	_____
28. A vascular disorder? _____	_____

29. Hospitalization for any mental disability for a period of six months or more?_____

_____

30. Hemophilia? _____ _____

31. Chronic osteomyelitis? _____ _____

32. Surgical or spontaneous fusion of a major weight-bearing joint? _____

_____

33. Muscular dystrophy? _____ _____

34. Thrombophlebitis? _____ _____

35. Total deafness? _____ _____

36. Any permanent physical condition which constitutes a 20% impairment of a part of or of the body as a whole? _____ _____

37. Head injury? _____ _____

38. Allergy to products containing latex? _____ _____

39. Other allergies or asthma? _____ _____

40. A back injury or disease process of the back resulting in disability over a total of 120 days?_____

_____

41. Any injury, operation, or any disability not covered in the above questions? _____

_____

42. Is there any question you did not understand?_____

Which question?_____

All statements and information given in this questionnaire are true, to the best of my knowledge and belief.

Volunteer Name (PRINT) _____
Signature_____ **Date**_____

Parent/Legal Guardian Name (PRINT) _____
Signature_____ **Date**_____

To Be Completed By Employer
Reviewed by_____ Date_____

SCHEDULE ORIENTATION

Please email the volunteer manager at volunteerservices@weismanchildrens.com to set up an orientation date.

THIS PART OF THE APPLICATION WILL BE COLLECTED DURING ORIENTATION.