**TEACHER OR COUNSELOR EVALUATION FORM**

STUDENT DATE

We are excited to inform you that the student named above has applied for our summer Junior Volunteer Program at Aspirus Keweenaw Hospital & Clinics. We would greatly appreciate your assistance in providing a profile of the student based on the knowledge that you have of her/his abilities, as well as any problem areas. Once we receive this completed questionnaire, we can begin the evaluation process.

If you do not know the student well enough to complete this questionnaire, please refer it to teacher who can best answer the following questions. All confidence will be respected.

Thank you,

Jennifer Jenich-Laplander

Volunteer & Community Relations Coordinator

If appropriate, please rate the student in each of the following categories:

RELATIONS WITH OTHERS (circle one):

 1 2 3 4 5 6 7 8 9 10

 Well accepted Works poorly with others

INITIATIVE (circle one):

 1 2 3 4 5 6 7 8 9 10

 Self-Starter Cautious Must be led

JUDGEMENT (circle one):

 1 2 3 4 5 6 7 8 9 10

 Exceptionally good Average Consistently poor

DEPENDABILITY (circle one):

 1 2 3 4 5 6 7 8 9 10

 Completely dependable Usually Unreliable

ABILITY TO LEARN (circle one):

 1 2 3 4 5 6 7 8 9 10

 Very quick Average Poor

QUALITY OF WORK (circle one):

 1 2 3 4 5 6 7 8 9 10

 Excellent Average Poor

ADDITIONAL COMMENTS: ­­­­­­­

Signature of evaluator

 Name Title



**JUNIOR VOLUNTEER PROGRAM CONSENT FORM**

Name in full Date

Address Telephone

City and State Zip Code

Birth Date Age in Years

 (Month) (Day) (Year)

CONSENT FOR MINOR TO PARTICIPATE IN VOLUNTEER ACTIVITIES

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ has my consent to serve as a volunteer at Aspirus Keweenaw Hospital & Clinics. I certify that the above birth date is correct, and I understand the responsibility of a Junior Volunteer and will encourage his/her promptness and regularity of service.

I hereby authorize Aspirus Keweenaw Hospital & Clinics to provide emergency medical assistance to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ if he/she becomes ill or injured while at Aspirus Keweenaw Hospital & Clinics doing volunteer services.

Signature of parent/guardian Date



**For Office Use Only**

Interview

Orientation

Assignment

To Begin

**JUNIOR VOLUNTEER PROGRAM APPLICATION**

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last Name First Name Middle Initial

Street Address City State Zip Code

Telephone #: School Grade

Birth Date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age in Years:

 (Mo.) (Day) (Year)

Parent/Guardian’s Name:

Emergency Telephone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your skills, hobbies and other interests?

Previous or present volunteer and/or work experience?

What kind of volunteer job are you interested in?

Are you willing to make a 3-month commitment to Aspirus Keweenaw Hospital & Clinics? (circle one): YES or NO

What days/times are you able to volunteer?

Mon.\_\_\_\_\_\_\_ Tues. \_\_\_\_\_\_\_ Wed.\_\_\_\_\_\_\_ Thurs. \_\_\_\_\_\_\_ Fri. \_\_\_\_\_\_\_ Sat. \_\_\_\_\_\_\_ Sun. \_\_\_\_\_\_\_

Morning Afternoon Evening Holidays

 Signature