CoxHealth Medical Explorers Springfield Summer Application

CoxHealth Medical Explorers Springfield Spring — Completed Applications will be accepted March 1, 2024 through March 28, 2024.

Thank you for applying to CoxHealth Medical Explorers Post 229, Springfield for Spring

Medical Explorers is a branch of Boy Scouts of America. CoxHealth is the 2nd oldest and the largest post in the United States. The Boy Scout Application must be completed. The form is on page 8 of this application. Parent/Guardian and student signatures are required.

Your application must be readable. To complete your application, please provide the following:

- ☐ **This completed registration form (New and returning students)**
- ☐ **Results of your TB skin test** (must be read **48 to 72 hours** after administration) **(New and returning students)**
- ☐ **Boy Scout Application** (page 8) **(New and returning students)**
- ☐ **Personal Documentation:**
  - **Complete immunization record** (see requirements on page 5)
  - **Social security number—(New students)**
- ☐ **Copy of current grade record (3.0 GPA or higher) (New and returning students)**
- ☐ **One letter of professional recommendation from a counselor, principal, teacher, etc. —(New students)**
- ☐ **Email address** (one that you check often) **School emails do not work or allow my emails to come through. Please use a personal email. Please do not use a parent's email.**
- ☐ **Parent/Guardian and student signatures (New and returning students)**
- ☐ **Registration fee payment** (see page 9 for financial assistance) **(New and returning students)**

Completed application deadline is Thursday, March 28th at noon.

If you wish to pay by credit/debit card, please fill in the following information. This information will **not** be kept on file.

Name on card: _____

Card Number: _____

Expiration Date: _____

Security Code: _____

Type of Card ___ Master Card ____Discover ___ Visa

Questions? Call 417/269-5954 or email kathy.shirley@coxhealth.com

CoxHealth Medical Explorers Springfield Summer Application

☐ NEW EXPLORER ☐ RETURNING EXPLORER

All fields <u>required</u>.

Explorer Information—Please use ink or type

Name: _____ DOB: __/__/___ SSN: _____-___-_____

Last First Middle Month/Day/Year Required

Address: _____

Complete Street Address City State Zip

Home phone: (____) _____-_____ Mobile: (____) _____-_____ School _____

Email (**required, print clearly**): _____@_____

(Student email address is required. Please do not use a school address or parents. This is how we communicate with students)

Emergency contact name/relationship: Name: _____ Relationship _____

Emergency contact phone: (____) _____-_____ Parent email (not required) _____@_____

Meetings—<u>Orientation—Thursday, April 4, 2024 at 6pm in Foster Auditorium</u> —Attendance at the Orientation meeting <u>IS REQUIRED FOR ALL NEW AND RETURNING EXPLORERS</u>. Only one meeting time is offered. If you are unable to attend you must wait until the next enrollment. All other meetings are held the 3rd Tuesday of the month at 6:00 pm.

Uniform

Students will need to try on scrubs and take photo for ID badges at the time they drop off their completed application to the Volunteer Office at Cox South Hospital Springfield.

Fees—Your registration fee covers all normal activities, uniform and Medical Explorer dues for **one year**.

Cash, credit/debit cards, and checks accepted—please make checks payable to CoxHealth Medical Explorers.

____ $110 for **new** Medical Explorers—final deadline to register is **<u>Thursday, March 28, 2024 at noon.</u>**

____ $75 for **returning** Medical Explorers that do not require new scrubs. **Please make sure that your scrubs still fit and are in good shape.** Final deadline to register is **<u>Thursday, March 28th at noon.</u>**

<u>You must be 15 years old by April 4, 2024 to enroll for this session.</u>

Submit registration form, all required documentation and payment <u>together in one packet.</u> ***A limited number of Medical Explorers are accepted each year. The number of Medical Explorers we accept for our program depends on the available opportunities throughout the hospital.***

You may submit your application at the Volunteer Office at Cox South or by mail.

CoxHealth Medical Explorer-Volunteer Office-3801 S. National –Springfield, MO 65807

(<u>Mailed Applications must be received by</u>* <u>March 28th at noon</u> *)

***<u>Deadline for Applications Thursday, March 28th</u>* <u>at noon</u>**

<u>Incomplete applications will not be accepted!</u>

FOR OFFICE USE ONLY # _____ $_____ ___cc ____ c Date _____ Complete _____ Scanned _____ VR ____ Picture _____

CoxHealth Medical Explorers Springfield Summer Application

PARENT/GUARDIAN PERMISSION AND RELEASE (required for Medical Explorer students **ages 15-17**)

Name of Student: _____

Parent/Guardian's Name: _____

Relationship: _____

Address: _____

Home Phone: _____

Mobile: _____

Email: _____

I hereby authorize my minor child or the minor child in my legal custody to participate in the Medical Explorers program at Lester E. Cox Medical Centers, dba Cox Medical Centers and/or at one of its subsidiaries or affiliates ("Program"). I understand that the purpose of the Program is to introduce students to the medical field and to provide opportunity for students to experience hospital operations. I verify that my child is between the ages of 15 and 17 and that the information contained in this application is correct.

If any condition arises for which my child needs medical treatment, I give my permission for such treatment to be given. I understand that I will be financially responsible for any treatment rendered and accept all responsibilities for my child.

I hereby agree to indemnify, defend and hold harmless Lester E. Cox Medical Centers dba Cox Medical Centers ("Cox Medical Centers"), its parent corporation, subsidiaries, affiliates, directors, employees, agents, volunteers and physicians (employed and independent) from any claim or lawsuit as a result of injuries or damages to my child or any other individual that may occur as a result of my child's participation in the Program.

I take full responsibility for my child's transportation, prompt arrival and departure from all activities. I understand that Cox Medical Centers is not responsible for my child should he/she leave the premises unattended.

I hereby consent to the taking of any photographs and the use of those photographs for promotional purposes. I hereby grant to Cox Medical Centers, with respect to photographs, motion pictures, video recordings, or any other record of the Program, in which my child may be included, to copyright the same in its own name or otherwise; to use, reuse, publish and re-publish in the same, in whole or in part, in conjunction with any printed matter in any and all media now or hereafter known, and for any purpose whatsoever, for illustration, promotion, art, advertising and trade, or any other purpose; and to use my child's name and any statement made by my child in connection therewith, if Cox Medical Centers so chooses.

I certify that I have read, fully understand, and agree to the above.

_____

Parent/Guardian's signature (required for Medical Explorers aged 15-17) *Date*

If your student is 15 through 17 years old, please fill out and sign this form

CoxHealth Medical Explorers Springfield Summer Application

STUDENT/PARENT/GUARDIAN PERMISSION AND RELEASE (required for Medical Explorer students **aged 18 or older)**

Name of Student: _____
Parent/Guardian's Name: _____
Address: _____
Home Phone: _____
Mobile: _____
Email: _____

We, _____("Student")
(name of Medical Explorers student)
and_____("Parent/Guardian")
(name of parent/guardian of Medical Explorers student)

hereby authorize Student to participate in the Medical Explorers program at Lester E. Cox Medical Centers, dba Cox Medical Centers and/or at one of its affiliates or subsidiaries ("Program"). Student and Parent/Guardian understand that the purpose of the Program is to introduce students to the medical field and to provide opportunity for students to experience hospital operations. Student is aged 18 or older and the information contained in this application is correct.

If any condition arises for which Student needs medical treatment, Student and Parent/Guardian hereby give permission for such treatment to be given. Student and Parent/Guardian understand that Student and Parent/Guardian will be financially responsible for any treatment rendered and accept all responsibilities for Student.

Student and Parent/Guardian hereby agree to indemnify, defend and hold harmless Lester E. Cox Medical Centers dba Cox Medical Centers ("Cox Medical Centers"), its parent corporation, subsidiaries, affiliates, directors, employees, agents, volunteers and physicians (employed and independent) from any claim or lawsuit as a result of injuries or damages to Student or any other individual that may occur as a result of Student's participation in the Program.

Student and Parent/Guardian take full responsibility for Student's transportation, prompt arrival and departure from all activities. Student and Parent/Guardian understand that Cox Medical Centers is not responsible for Student should he/she leave the premises unattended.

Student and Parent/Guardian hereby consent to the taking of any photographs and the use of those photographs for promotional purposes. Student and Parent/Guardian hereby grant to Cox Medical Centers, with respect to photographs, motion pictures, video recordings, or any other record of the Program, in which Student may be included, to copyright the same in its own name or otherwise; to use, reuse, publish and republish in the same, in whole or in part, in conjunction with any printed matter in any and all media now or hereafter known, and for any purpose whatsoever, for illustration, promotion, art, advertising and trade, or any other purpose; and to use Student's name and any statement made by Student in connection therewith, if Cox Medical Centers so chooses.

I certify that I have read, fully understand, and agree to the above.

_____

Parent/Guardian's signature *Date*

_____

Student's signature *Date*

If your student is 18 years old before the first meeting, please fill out this form. Both signatures are required

CoxHealth Medical Explorers Springfield Summer Application

IMMUNIZATION RECORD

Name: _____

Last *First*

Middle

We are dedicated to protecting you and our patients from infectious disease.

Clinical documentation of the following immunizations is required PRIOR to beginning your Medical Explorer experience. Documentation must be from a medical provider or signed immunization record. CoxHealth Employee Health will review your documentation for accuracy.

If you need any of the required immunizations listed below, please contact your primary care physician or the health department for the county in which you live to schedule an appointment.

Please attach documentation for the following:

___ Negative **TB** test or treatment **within last 12 months** (Required for new and returning Medical Explorers)
This test takes 48 to 72 hours to complete. **Please make sure you have the results with the application.**

___ **Hepatitis B** series of 3 shots
Hep B 1, Hep B 2 and Hep B 3 or positive Hepatitis titer (test)

___ **Varicella/chicken pox** series of 2 shots Varicella 1 and Varicella 2 or positive Varicella titer (test)

Note: If you have had chicken pox, you must provide documentation from your medical provider showing the dates that the illness occurred. If dates are not available, you must provide documentation that you received the varicella titer test.

___ **MMR** (measles, mumps and rubella) series of 2 shots
MMR 1 and MMR 2 or positive MMR titer (test)

___ **Tdap** (tetanus, diphtheria and whooping cough)

I certify that I have read and fully understand the attached immunization record and believe it to be complete and true to the best of my knowledge.

_____ *Date* _____

Parent/Guardian's signature (required for Medical Explorer ages 15-17)

I certify that I have read and fully understand the attached immunization record and believe it to be complete and true to the best of my knowledge.

_____ *Date* _____

Medical Explorer's signature (for Medical Explorer 18 and over)

CoxHealth System Policy: Blood/Body Fluid Exposure & Follow-Up
Student/Faculty Acknowledgment and Agreement to Comply

I/My Child and I have reviewed and understand the Blood/Body Fluid Exposure and Follow-Up CoxHealth System Policy ("Policy"). I/My Child and I understand and agree to comply with the Policy, including any revisions made at CoxHealth's sole discretion, in the event of a blood/body fluid exposure during My/My child's educational experience (regardless of whether such exposure occurs during clinical or non-clinical activities) at CoxHealth, or at one of CoxHealth's related facilities or entities. I/My Child and I agree that in the event of a blood/body fluid exposure, My/My Child's labs will be drawn in compliance with the Policy. I/My child and I understand and agree that My/My Child's failure to comply with the Policy shall be grounds for My/My Child's immediate dismissal from My/My Child's educational experience at CoxHealth or at any of its related facilities or entities.

_____

Student Print name ***Signature*** ***Date***

_____

Parent/Guardian (required in addition to the student's signature above, if the student is under age 18)

CoxHealth Medical Explorers Springfield Summer Application

CoxHealth Interview, Photo and Video

MODEL RELEASE

In consideration of the terms stated below, I hereby give CoxHealth, its agents, employees and representatives, the absolute right and unrestricted permission to copy-right, use, publish, broad-cast and otherwise make use of interviews, pictures or videos of me and/or my child through tele-vision facilities, print media, CoxHealth publications, website, etc. using my own name or a fictitious name. I understand that I have the right to request cessation of the production of the recordings, films or other images. I hereby waive any right to inspect or approve the finished videotape, soundtrack, photograph, website or printed material that may be used in conjunction herewith or to the eventual case that it may be applied. I hereby release, discharge and agree to hold harmless CoxHealth, its agents, employees and representatives acting under its authority from and against any liability resulting from the contemplated use whatsoever.

I have read and fully understand this release. ***Please print.***

Parent/Guardian Information Date: _____

For Medical Explorer's younger than 18 years:

I hereby certify that I am the parent and/or guardian of Medical Explorer's. I hereby consent for the purpose set forth above.

Name: _____

Address: _____

Phone: _____

Email: _____

Parent's Signature _____

Student's 18 and over

Model Information Date: _____

Name: _____

Address: _____

Phone: _____

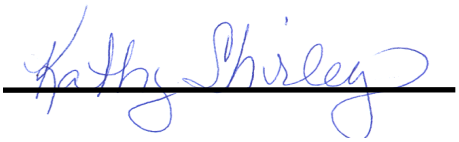
Email: _____

Medical Explorer's Signature _____

CoxHealth Employee Witness Date: **March 28, 2024**

Name: **Kathy Shirley**

Department: **Volunteer Services**



This form is read by machine. Please print the numbers and letters as shown on the sample application.

YOUTH PARTICIPANT

Post number: 229

If applicant has an unexpired participant certificate, participation may be accomplished in this unit by paying $1 for processing the transfer. Mark and attach certificate. It will be returned by the council.

◯ Transfer application Transfer from council number: Post number:

E-mail:

Name and address information **(Please print one letter in each space—press hard, you are making a copy.)**

First name **(No initials or nicknames)** | Middle name | Last name | Suffix

Country | Mailing address | City | State | Zip code

US

Home phone Date of birth (mm/dd/yyyy) Grade

Ethnic background:

◯ African American ◯ Native American ◯ Alaska Native ◯ Asian
◯ Caucasian/White ◯ Hispanic/Latino ◯ Pacific Islander ◯ Other

School

Gender: ◯ Male ◯ Female

Parent/guardian information ◯ Mark here if address is same as above.

◯ Mark here if the adult parent/guardian is not living at the same address; complete and attach a Learning for Life adult application.

Select relationship: ◯ Parent ◯ Guardian ◯ Grandparent ◯ Other (specify)

First name **(No initials or nicknames)** | Middle name | Last name | Suffix

Country | Mailing address | City | State | Zip code

US

Home phone Date of birth (mm/dd/yyyy) Occupation Employer Gender: ◯ M ◯ F

Business phone Ext. Previous Exploring experience Cell phone

Parent/guardian e-mail address

Kathy Shirley

Signature of post leader

03 / 28 / 2024

Date

I have read the attached information sheet and approve the application (signature of parent/guardian required if applicant is under 18 years of age).

Signature of parent/guardian

Signature of Explorer

6001

Registration fee $.

LOCAL COUNCIL COPY

28-309

Retain on file for three years.

Student and parent must sign this form

CoxHealth Medical Explorers Springfield Summer Application

Only fill this form out if you need assistance with fees.

OZARK TRAILS COUNCIL, INC — BOY SCOUTS OF AMERICA

ASSISTANCE APPLICATION

The Ozark Trails Council recognizes that some of our youth members cannot pay the full cost of some of the necessary requirements of the scouting program such as: Registration, Supplies, Uniforms, Transportation, or attending local council scouting events, such as summer camp, resident camp or day camp. For this reason, a **limited** financial assistance fund has been developed. This fund will assist deserving youth members with a **percentage** of the cost based on need, **but it is not intended to provide the full cost.** Families, troops, packs, and/or the chartered partner are expected to provide a **substantial portion of the fee.** This form may also be submitted for certain needs of an event such as Woodbadge, etc., by the event chairperson. Financial aid is for only one camp.

This form must be submitted to the Springfield Council Service Center. If the request is for an activity, this form should be submitted no later than 45 days prior to the event/activity. As funds are limited, applications will be reviewed on a date of submission basis. The information requested below is confidential. Please complete all appropriate sections so full and fair consideration may be given to help determine the percentage of need for each application. If the application has been granted for multiple fees or costs, a copy of this form must accompany each receipt submitted, or be presented at the Scout offices/Shop for each purchase. If this form is not presented, the purchase and/or receipt will not be honored.

PLEASE: PRINT CLEARLY. Complete *ALL* information and collect *ALL* signatures as required.
Hard to read, or missing information and/or signatures *WILL* cause the application to be denied.

Mail to: Ozark Trails Council, Inc., Attn: Program Coordinator, 1616 S. Eastgate, Springfield, MO. 65809. Or Fax to: 417-883-2534.

INDIVIDUAL ASSISTANCE APPLICANT – THIS IS NON-TRANSFERABLE
Funds will be returned to assistance account if not used by applicant named below.

Applicant's Name: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Age: _____ Pack / Troop / Crew / Post / Team (Circle One) Unit #: _____ Present Rank: _____ District: _____

Guardian:	Name	Relationship	Employer
Male:			
Female:			

Name and age of other children in the home: 1. _____ 2. _____ 3. _____ 4. _____ 5. _____ 6. _____

Total yearly net family income: ( ) under $10,000 ( ) $10,000 - $15,000 ( ) $16,000 - $20,000 ( ) $21,000 - $25,000 ( ) $26, 000 – $30,000 ( ) $31,000 - $40,000 ( ) $41,000 - $45,000 If over $45,000, list amount: _____

Do you qualify for the free or reduces lunch program? Yes_____ No_____

Has applicant participated in a money-earning project such as Popcorn Sales? Yes:_____ How much did applicant earn? **Total Sales – not percentage (see back of form)** $_____

No:_____ Why not? _____

Guardians' Signature: _____ (Print / Sign) **Date:** _____

State the circumstances which require financial assistance: (see back of form)

TO BE COMPLETED BY THE UNIT

We have indicated, below, the maximum support available from our own funds and we recommend approval of this request.

Unit Committee _____ (Print / Sign)

Unit Leader: _____ (Print / Sign)

Unit Leader's Address: _____ **Phone:** _____

City, State, Zip:

MONETARY BREAKDOWN

Total Amount of Fee/Cost: _____

How much of the fee/cost will be paid by Applicant and/or family: _____

Unit: _____

Chartered partner: _____

Total: _____

FINANCIAL ASSISTANCE REQUESTED:

FINANCIAL AID TO BE USED FOR:

Activity: CIRCLE ONE ONLY	DAY CAMP RESIDENT CAMP SUMMER CAMP
Assistance for: CIRCLE ONE ONLY	DAY CAMP FEES RESIDENT CAMP FEES SUMMER CAMP FEES
CAMP SESSION & DATE:	
OTHER EVENT:	
Date of Event:	

FOR EVENT ASSISTANCE ONLY

EVENT CHAIRPERSON: _____ (Print / Sign) **Date:** _____

FOR OFFICE USE ONLY

FINANCIAL AMOUNT APPROVED: _____ **DATE:** _____

DISTRICT EXECUTIVE APPROVAL: _____

SCOUT EXECUTIVE APPROVAL: