

# CoxHealth Medical Explorers Springfield Fall 2019

## CoxHealth Medical Explorers Springfield Fall 2019—Completed Applications will be accepted July 1, 2019—August 24, 2019

Thank you for applying to CoxHealth Medical Explorers Post 229, Springfield for Fall 2019.

Medical Explorers is a branch of Boy Scouts of America. CoxHealth is the 2<sup>nd</sup> 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 signature is 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 (2.5 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 always go through. Please use a personal one. Please do not use a parent's email. (New and returning students)
- 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 Saturday, August 24, 2019 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 417/269-4157 or email [pat.long@coxhealth.com](mailto:pat.long@coxhealth.com)

# CoxHealth Medical Explorers Springfield Fall 2019

NEW EXPLORER       RETURNING EXPLORER

*All fields required. Please type or print clearly and in ink.*

## Explorer Information

Name: \_\_\_\_\_ DOB: \_\_/\_\_/\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_

Address: \_\_\_\_\_  
Last First Middle Month/Day/Year Required  
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) \_\_\_\_\_@\_\_\_\_\_

## Open House—Cox South-Saturday, August 24, 2019 9:00 am to Noon – Meeting Room 3

Attendance at the open house is not required—if you do not make it, please stop by the Volunteer Office to turn in your application and have your picture taken. This is a come and go event. At the open house you can turn in your completed application, try on scrubs (they will be ordered then handed out a meeting), have your picture taken for your nametag, and ask questions.

## Meetings—Saturday, September 21, 2019 at 9:00 am in Foster Auditorium. Orientation—

Attendance at the first Medical Explorers meeting **IS REQUIRED FOR ALL NEW AND RETURNING EXPLORERS**. Only one meeting time is offered. If you are unable to attend you must wait until the next enrollment. Please see your handbook for meeting dates. All other meetings are held the 1st Tuesday of the month at 6:00 pm.

## Uniform

Scrubs are adult sizes (**sizes run big**). We have sizes in the office to try on. Additional sizes are available through special order. Ask for details. Please indicate your size below.

Top size: \_\_XXS \_\_XS \_\_S \_\_M \_\_L \_\_XL \_\_XXL Pant size: \_\_XXS \_\_XS \_\_S \_\_M \_\_L \_\_XL \_\_XXL

T-shirt size: \_\_S \_\_M \_\_L \_\_XL \_\_XXL \_\_XXXL

**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 payable to CoxHealth Medical Explorers.

\_\_\_\_ \$110 for **new** Medical Explorers—final deadline to register is **August 24, 2019 at noon**

\_\_\_\_ \$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 **August 24, 2019 at noon.**

**Submit registration form, all required documentation and payment together in one packet. 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 Open House, drop it by the Volunteer Office at Cox South or by mail.**

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

**(Mailed Applications must be received by August 23, 2019 at 4:00 pm )**

**Deadline for Applications Saturday, August 24, 2019 at noon**

**Incomplete applications will not be accepted!**

FOR OFFICE USE ONLY # \_\_\_\_\_ cc \_\_\_\_\_ c Date \_\_\_\_\_ Complete \_\_\_\_\_ Scanned \_\_\_\_\_ VR \_\_\_\_\_ Picture \_\_\_\_\_

# CoxHealth Medical Explorers Springfield Fall 2019

## 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 Fall 2019

## 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 Fall 2019

## 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)*

**Flu shots are required and will be given on October 1, 2019 starting at 5:00 pm. Flu shots will be given at no charge. Parent permission slips will be sent out prior to this meeting. If you receive your flu shot anywhere else than Employee Health at CoxHealth, you must submit written documentation before October 18, 2019. If you do not receive a flu shot you will not be allowed to attend meetings or rotations during flu season.**

# CoxHealth Medical Explorers Springfield Fall 2019

## 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/Faculty:

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*Student Print name*

*Signature*

*Date*

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

### TOBACCO POLICY

I understand that effective November 21, 2013, CoxHealth and its Affiliates will no longer place individuals for volunteer service who use tobacco products. By submitting this Application for Volunteering, I represent and agree (1) if placed after November 21, 2013 CoxHealth will not accept me as a volunteer if I am a tobacco user or test positive for nicotine use, (2) CoxHealth pre-placement procedures include urine screening for nicotine use, (3) if an offer of volunteer placement has been extended, CoxHealth will withdraw the offer if I am in violation of this policy, and (4) if placed in volunteer service by the CoxHealth after November 21, 2013, I will not during my volunteering use any tobacco product. I understand that use of a tobacco product during my volunteer service with the System is grounds for corrective action which may include immediate termination of volunteer placement.

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*Medical Explorer's signature*

*Date*

# CoxHealth Medical Explorers Springfield Fall 2019

## 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: **September 14, 2019**

Name: **Pat Long**

Department: **Volunteer Services**

  
\_\_\_\_\_





# CoxHealth Medical Explorers Springfield Fall 2019

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

OSARK 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.

<b>INDIVIDUAL ASSISTANCE APPLICANT – THIS IS NON-TRANSFERABLE</b>			
Funds will be returned to assistance account if not used by applicant named below.			
Applicant's Name: _____		Phone: _____	
Address: _____		City: _____	State: _____ Zip: _____
Circle One			
Age: _____	Pack / Troop / Crew / Post / Team _____	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?		How much did applicant earn?	
Yes: _____		Total Sales – not percentage ( see back of form) \$ _____	
No: _____ Why not? _____			
Guardians' Signature: _____			Date: _____
Print		Sign	
State the circumstances which require financial assistance: (see back of form)			

<b>MONETARY BREAKDOWN</b>		<b>FINANCIAL AID TO BE USED FOR:</b>	
Total Amount of Fee/Cost: _____		Activity: CIRCLE ONE ONLY DAY CAMP RESIDENT CAMP SUMMER CAMP	
How much of the fee/cost will be paid by Applicant and/or family: _____			
Unit: _____		Assistance for: CIRCLE ONE ONLY DAY CAMP FEES RESIDENT CAMP FEES SUMMER CAMP FEES	
Chartered partner: _____			
Total: _____		CAMP SESSION & DATE: _____	
FINANCIAL ASSISTANCE REQUESTED: _____		OTHER EVENT: _____	
		Date of Event: _____	

<b>FOR EVENT ASSISTANCE ONLY</b>	
EVENT CHAIRPERSON: _____	Date: _____
Print	Sign

<b>FOR OFFICE USE ONLY</b>	
FINANCIAL AMOUNT APPROVED: _____	DATE: _____
DISTRICT EXECUTIVE APPROVAL: _____	_____
SCOUT EXECUTIVE APPROVAL: _____	_____

