CoxHealth Medical Explorers Branson Spring 2020

CoxHealth Medical Center Branson Spring 2020-Completed applications will be accepted December 13, 2019 to January 27, 2020.

Thank you for applying to the CoxHealth Medical Explorers Post 229, Branson for Spring 2020.

Medical Explorers is a branch of Boy Scouts of America Post 229. CoxHealth is the 2nd oldest and the largest post in the United States. **The Boy Scouts 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 most 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 e-mails do not always go through. Please use your personal e-mail address.**
- ☐ **Parent/Guardian and student signatures must be on forms requiring necessary signatures (New and Returning students)**
- ☐ **Registration fee payment** (see page 9 for financial assistance) **(New and Returning students)**

Completed application deadline is Monday, January 27, 2020 at 4 p.m.

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 417/335-7059 or email ruth.huntsman@coxhealth.com

CoxHealth Medical Explorers Branson Spring 2020

☐ NEW EXPLORER ☐ RETURNING EXPLORER *School Name* _____ *Grade* _____

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

Explorer Information

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

Last First Middle Month/Day/Year Required

Address: _____

Complete Street Address City State Zip

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

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

(this is how we communicate with students)

Emergency contact name/relationship: Name: _____ Relationship _____

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

Meeting—Monday, February 17, 2020 at 5:30 p.m. in hospital Tree rooms

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 first Monday of the month at 5:30 pm.

Uniform

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

Top size: __ XS __S __ M __ L __ XL __XXL **Pant size:** ___ XS ___ S ___ M ___L __ XL __XXL

T-shirt size: __S __ M __ L __ XL __ XXL

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 **Monday, January 27, 2020 at 4 p.m.**

____ $ 75 for **returning** Medical Explorers that do not require new scrubs. **Please make sure your scrubs still fit and in good shape.** Final deadline to register is **Monday, January 27, 2020 at 4 p.m.**

You must be 15 years old by March 2, 2020 to enroll for this session.

Submit registration form, all required documentation and payment together in one packet.

You may bring by your completed application to the Medical Explorer Office Plaza One Building, Suite 403, or by mail to:

Ruth Huntsman, CoxHealth Medical Explorer Coordinator

Suite 403, 101 Skaggs Road, Branson, MO 65616

(Mailed Applications must be received by Monday, January 27, 2020 at noon).

Incomplete applications will not be accepted!

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

CoxHealth Medical Explorers Branson Spring 2020

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 ages 15-17) *Date*

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

CoxHealth Medical Explorers Branson Spring 2020

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 Branson Spring 2020

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)

___ **2019-2020 Flu Shot documentation**

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/Faculty:

_____

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

_____

Parent/Guardian Print name ***Signature*** ***Date***

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

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 con-junction 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: _____

Name: **Ruth Huntsman**

Department: **Branson Volunteer Services**

Ruth Huntsman

_____

CoxHealth Medical Explorers Branson Spring 2020

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

YOUTH PARTICIPANT

Post number: 2 2 9

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 - - X Ext. Previous Exploring experience Cell phone - -

Parent/guardian e-mail address

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

Ruth Huntsman

Signature of post leader

/ /

Date

Signature of parent/guardian

Signature of Explorer

6001 Registration fee $.

LOCAL COUNCIL COPY

Retain on file for three years. 28-309

CoxHealth Medical Explorers Branson Spring 2020

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: