

School Faculty - Evaluation

Student's Name: _____

School Name: _____ Grade: _____

Consent To Release Student Information

I, the parent or guardian of the student identified above, authorize a school faculty member or authorized representative to complete the School Faculty Evaluation Form supporting their application to the Teen Volunteer Program at Bergen New Bridge Medical Center. I understand that the Medical Center solely uses this evaluation to help select qualified Teen Volunteers. I voluntarily waive my right to review the completed form.

All information provided by the school will remain confidential.

Name of Parent or Legal Guradian: _____

Signature of Parent or Legal Guardian: _____ Date: _____

Following Section to Be Completed by School Faculty Member

I would rate this student as follows:

1. Requires less more about the same amount of instructions as most students.
2. Requires minimal occasional considerable supervision or direction.
3. Does Does Not follow through on assignments
4. Works well very well not well in a team
5. Is Is not likely to be comfortable in a hospital setting.
6. Is Is not regular in school attendance. If not, what is the cause of absence or tardiness?

I recommend this candidate to be accept as a Teen Volunteer at Bergen New Bridge Medical Center.

Yes No

Explain: _____

Name of School Faculty: _____

Signature of School Faculty: _____ Date: _____

Reference Forms should be submitted to Joshua Remland at jremland@newbridgehealth.org