

CoxHealth Medical Explorers Springfield Fall 2025

CoxHealth Medical Explorers Springfield — Completed Applications will be accepted August 1—September 9

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 Tuesday, September 9 at 12pm

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 joy.davis@coxhealth.com

CoxHealth Medical Explorers Springfield Fall 2025

☐ NEW EXPLORER ☐ RETURNING EXPLORER

All fields required.

Explorer Information—Please use ink or type

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—Bring completed applications, take your picture, try on uniforms—
Saturday, August 30 from 1:30-3:30pm in Foster Auditorium

Meetings—Orientation—Thursday, September 11, 2025 at 6pm in Foster Auditorium —
Attendance at the Orientation 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. All other meetings are held the 3rd Tuesday of the month at 6:00 pm.

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 **December 27, 2024**

_____ \$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 **Friday December 27, 2024 at 4PM.**

You must be 14years old by January 7, 2025 to enroll for this session.

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 Volunteer Office at Cox South or by mail.

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

Deadline for Applications is September 9, 2025 by 12PM

Incomplete applications will not be accepted!

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

CoxHealth Medical Explorers Springfield Fall 2025

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 14 through 17 years old, please fill out and sign this form

CoxHealth Medical Explorers Springfield Fall 2025

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 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 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 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 Fall 2025

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 9, 2025

Name: **Joy Davis**

Department: **Volunteer Services**

Joy Davis

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

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
 Gender: ☐ Male ☐ Female

School

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

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

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

Joy Davis

Signature of post leader

09 / 09 / 2025

Date

Signature of parent/guardian

6001

Registration fee \$

Signature of Explorer

Student and parent must sign this form

CoxHealth Medical Explorers Springfield Fall 2025

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: _____
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 () under \$10,000 () \$10,000 - \$15,000 () \$16,000 - \$20,000 () \$21,000 - \$25,000 () \$26,000 - \$30,000			
family income: () \$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: _____ 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)			

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

FOR EVENT ASSISTANCE ONLY	
EVENT CHAIRPERSON: _____	Date: _____
Print	Sign

FOR OFFICE USE ONLY	
FINANCIAL AMOUNT APPROVED: _____	DATE: _____
DISTRICT EXECUTIVE APPROVAL: _____	
SCOUT EXECUTIVE APPROVAL: _____	

