SOUTH JERSEY DREAM CENTER

Breaking the cycle of poverty in South Jersey

Youth Volunteer Waiver

Group Name (if applicable): _____ Date: ___/___/_____

Volunteer Name: _____ Birthday: ___/___/_____

(The minimum age for volunteers is 12 years old, with the exception of family events when the minimum age is 6 years old)

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

Email: _____

Cell Phone: _____ Home Phone: _____

Parent or Guardian Contact Information

Parent or Guardian Name: _____

Mailing Address (if different from above): _____ City: _____ State: ____ Zip:_____

Email: _____ Phone Number: _____

Parents/Guardian's Employer: _____

Health Insurance Co.: _____ Policy No.: _____

Physician: _____ Phone: _____

Does your insurance carrier require a second opinion before emergency procedures are undertaken?

❒ Yes ❒ No Date of last tetanus shot: ___/___/_____

Listed below are any allergies to medications, medical conditions, or other information important to my child's health that the chaperons and/or medical providers should know.

_____

Emergency Contact Information *(If different from previous parent or guardian contact information)*

Name: _____ Phone Number: _____ Relation: _____

Volunteer Interest:

Please let us know if you have any skills you'd like to contribute:

_____

Please tell us how you learned about the South Jersey Dream Center:

❒ Friend ❒ Website ❒ Social Media ❒ Event ❒ Other: _____

Medical Release:

(Youth's name) _____ has my permission to volunteer at the South Jersey Dream Center. I authorize such emergency or other medical treatment as the emergency personnel deem necessary or appropriate. I understand that the South Jersey Dream Center leadership will use all reasonable effort to contact me or the person listed above before the administration of such treatment, but if they cannot so contact me or the person listed below, they are authorized to allow/authorize such medical care. I understand that they will make reasonable efforts to continue to contact me while such treatment is on-going.

I understand that volunteering at the South Jersey Dream Center involves physical labor activities, and I acknowledge that reasonable measures will be taken to safeguard the health and safety of all participants. I agree to indemnify and hold harmless the South Jersey Dream Center, its officers, agents and employees from any and all claims, damages, expenses or injuries arising out of or incident to my child's participation at the South Jersey Dream Center, unless such a loss or injury results directly from the neglect or willful act of an officer, agent or employee of the South Jersey Dream Center acting within the scope of his/her employment.

_____ _____ _____

Volunteer's Signature Date Volunteer's Name

_____ _____ _____

Parent/Guardian's Signature (if under 18) Date *Parent/Guardian's Name (if under 18)*

Your signature here confirms that the information on these two pages is complete and correct as far as you know, and that you are giving permission to staff as noted.

_____ _____

Parent/Guardian's Signature Date

Information contained herein is confidential and will be made available only to staff and medical professionals as necessary.

Media Release

The South Jersey Dream Center has my permission to use photographs or videos in which my child, _____, appears for the South Jersey Dream Center publicity purposes.

_____ _____

Parent/Guardian's Signature Date