PARENT/GUARDIAN CONSENT:

I am aware of, encourage, and support my child's decision to volunteer in the Crouse Health Junior Volunteer Program. I understand that a decision to volunteer in this program requires a commitment of a minimum of 4 hours per shift and support the hospital and my child in his/her effort to honor the commitment. I understand that if a letter of recommendation or completion is requested my child must complete 40 hours of service prior to receipt.

I also understand that all volunteers at the hospital must meet health office requirements which include submission of copies of proof of medical examination within one year of the application and a record of inoculations. In addition, all volunteers are required to undergo a TB Gold test administered by Crouse Health Lab Alliance. Your signature indicates that we have your permission to complete the above requirements.

Printed Child's First and Last Name

Parent/Guardian printed Name

Parent/Guardian Signature

Date: _____