

YOUTH Volunteer Information Form

Contact Information

Volunteer's Name: _____ **Birth date:** _____

Address: _____

E-mail address: _____ **Cell Phone:** _____

Program(s) volunteering with: _____ **Supervisor(s):** _____

Program(s) volunteering with: _____ **Supervisor(s):** _____

Emergency Contact Name: _____ **Phone Number:** _____

Signature of Volunteer: _____ **Date:** _____

Parent Permission for Youth Volunteers

I, _____, give my permission for _____
(Parent/guardian name – **please print**) (Volunteer name – **please print**)

to volunteer without compensation for the Garrett County Health Department.

Parent/Guardian Signature: _____ **Date:** _____

Communication Method for Youth Volunteers

Please choose the method of communication you would prefer for information about your child's volunteer program.

I give permission for my child to be contacted by health department staff in reference to the program. This could be by text, email, or a phone call.

I also give permission for my child to participate in Google Meets for group meetings.

OR

I prefer that all communication about the program be done directly with me. My contact number is

_____.

Please Complete Both Sides



Garrett County, a healthier place to live, work, and play!

garretthealth.org

Toll Free Maryland Department of Health 1-877-463-3464

TDD for Disabled Maryland Relay Service 1-800-735-2258

Equal Opportunity Employer

Consent to Use Information for Public Health Programming and Public Relations

I hereby agree to allow the Garrett County Health Department and its representatives to use my child’s name, photographic likeness, and/or video/audio recording for the purpose of community health education and public awareness.

I give to the Garrett County Health Department, or its authorized representatives, permission to produce, reproduce, display, advertise, loan, or otherwise distribute any and all photographs, film, television productions, or other media made by or for them in the public interest without limitation or reservation. In giving my consent, I agree to hold harmless the Garrett County Health Department, its agents, or representatives responsible in any way, regarding the use and release of this information.

Signature of Parent or Guardian **Date**

Signature of Witness **Date**

Volunteer Acknowledgement of Risk

I acknowledge that the volunteer work my child agrees to perform may involve risk of personal injury or illness. However, I agree to allow him or her to perform the duties assigned.

Signature of Parent or Guardian **Date**

Parent Consent for Youth Evaluation

PLEASE CHECK ONE:

- I AGREE to let my child complete the Youth Health Survey.
- I DO NOT agree to let my child complete the Youth Health Survey.

Signature of Parent or Guardian **Date**

Thank you for your participation!

Revised 9-29-2020



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