ASPIRUS VOLUNTEERS – TEEN VOLUNTEER PROGRAM
PARENTAL PERMISSION

DATE: _____

I hereby give permission for my son or daughter, _____, to participate in the Volunteen Program at Aspirus Medford Hospital. I certify that my son or daughter is 14 years of age or older.

I also authorize any related health screening that is required by the hospital for participation in the Volunteen Program.

I understand that this a volunteer position and as a Volunteen my son or daughter is making a commitment not only to themselves, but also to Aspirus Medford Hospital, its patients and the community. I also understand that he or she has an obligation to follow Volunteen program guidelines and to carry out the responsibilities taken.

I would like to take part in this commitment by promising to encourage my son or daughter in this effort. I understand that I will be responsible for transportation to and from the health center.

_____
Signature of Parent or Guardian

_____
Address

_____
Telephone