WESTERN RESERVE HISTORICAL SOCIETY

Short Term
Minor Volunteer Service

Date/s of Service: _____

Minor Contact Information

Name_____

Mailing Address_____

City _____ State_____ Zip _____

Date of Birth_____ Age_____ School Minor Attends _____

Parent or Guardian Consent

Name of Parent or Guardian_____

Relationship to Minor _____

Mailing Address_____

City _____ State_____ Zip _____

Telephone_____ Email _____

Alternate number_____

Emergency Contact Information (if different from above)

Name _____

Mailing Address _____

City _____ State _____ Zip _____

Telephone _____ Alternate number _____

I hereby certify that to the best of my knowledge and belief, the above statements are true and that the minor named above may volunteer with my approval.

Signature of Parent or Guardian _____

Date Signed _____

The Volunteer Office shall retain a copy of the statement of consent with the minor's volunteer records.

Photography Consent Information

Participants will be photographed for educational, archival, public relations and security purposes for the Western Reserve Historical Society and the Volunteer Program.
I acknowledge that the volunteer may be photographed by the Western Reserve Historical Society and through my signature; I consent to this action for the minor.

Signature of Parent or Guardian: _____ **Date:** _____

Medical Release for Minors

Medical Authorization and Hold Harmless Agreement

I agree that Western Reserve Historical Society shall not be responsible for any personal injuries or losses sustained by the minor while on Western Reserve Historical Society premises or as a result of any agency sponsored activities. I further agree to indemnify and save harmless Western Reserve Historical Society from any claims or demands arising out of such injuries or losses.

Signature of Parent or Guardian: _____ **Date:** _____

Parental Consent

Today's Date _____
(This form is valid for one year following today's date)

Minor's Name _____
Address_____
City/State/Zip _____
Date of Birth _____ **SSN** _____

Parent/Guardian Name _____
Home Phone _____ **Cell Phone** _____
Work Phone _____

Is the minor currently taking medicine or treatment? Yes No
If yes, explain _____

Has (s)he ever had a severe reaction to a bee/hornet sting or insect bite? Yes No
If yes, explain _____

List any Allergies:
Food _____
Drugs _____
Other (e.g., insects, plants) _____

In case of emergency, please contact:

1. Name/Relationship:_____ Phone Number:_____
2. Name/Relationship:_____ Phone Number:_____
3. Name/Relationship:_____ Phone Number:_____

Primary Care Physician:

Name:_____ Address: _____
Phone: _____
Insurance Company: _____
Policy number: _____

Please be sure to update the Volunteer Office if any of the above information changes.

Parental Authorization for Treatment of a Minor

Being the parent or legal guardian of _____, *(minor's name printed)* I _____ *(parent/guardian's name printed)* do consent to any x-ray, anesthetic, medical, surgical, or dental diagnosis or treatment that may be deemed necessary for my minor child. Further, I understand that all efforts will be made to contact me prior to treatment. In the event that I cannot be reached in an emergency, I give permission to the Western Reserve Historical Society and/or the attending physician to make the decisions necessary for treatment. I further understand that the doctors, dentists, and other providers attending to my child will take all reasonable safety precautions during their care.

The undersigned further acknowledges and agrees that they will be completely and wholly responsible for the payment of any and all such medical bills for injuries or illness not covered under worker's compensation, and do further hereby agree to fully indemnify, release and hold harmless the Western Reserve Historical Society from any liability or claims that may arise out of the minor's injuries or medical treatment or care given as a result thereof.

Parent/Guardian Signature _____ **Date**_____

Please, note any additional information here:

_____
_____
_____
_____