CITY OF FULLERTON
PARKS & RECREATION DEPARTMENT
TEEN VOLUNTEER APPLICATION

Please fill out the information listed below and return it at your earliest convenience. Please make sure that all information is completed. WE DO NOT ACCEPT COURT MANDATED COMMUNITY SERVICE.

PLEASE PRINT OR TYPE: Date: _____

Name: _____ Birth Date: _____
(LAST) (FIRST)

Address: _____
(NUMBER / STREET) (CITY) (ZIP CODE)

NAME OF PARENT OR LEGAL GUARDIAN: _____

HOME PHONE NUMBER: (_____) _____ WORK PHONE NUMBER: (_____) _____

CELL PHONE / PAGER NUMBER: (_____) _____

Hours of Availability:

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

Please check one:

____ My child may walk home at _____.
(Time)

____ I will have an adult pick up my child from the program location.

Name of adults (18 years of age) authorized to pick up my child:

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

AUTHORIZATION FOR MEDICAL TREATMENT

I / We the undersigned parent(s) / Legal guardian(s) of _____, a minor, do hereby consent to and authorize the CITY OF FULLERTON and/or its officers, officials, agents, contractors, volunteers, boards, departments, servants or employees to obtaining necessary emergency medical care including X-ray, examination, anesthetic, medical or surgical diagnosis or treatment and hospital care for my/our child which is deemed advisable and rendered under the general or special supervision of a medical professional, including doctors, nurses, medical technicians, emergency room staff, EMTs, and paramedics.

I / We acknowledge that the CITY OF FULLERTON is not responsible for paying for the costs of any such emergency medical treatment that does not arise from the course or scope of the duties performed by my/our child on behalf of the CITY OF FULLERTON and that the CITY OF FULLERTON has no insurance to pay for the medical costs arising form such injuries, illnesses or medical conditions. I / We further agree that any such medical or related expenses incurred by my / our child will be my / our sole responsibility. (This does not apply to state mandated Workers' Compensation benefits.)

THIS AUTHORIZATION SHALL REMAIN IN EFFECT FOR TWO YEARS FOR THE DATE SIGNED OR UNTIL _____. The Undersigned hereby agrees to inform the CITY OF FULLERTON of any changes to the information contained within this authorization as soon as such new information is available. This authorization is given pursuant to the provisions of Family Code 6910.

EMERGENCY CONTACT (SECONDARY): _____
(NAME) (RELATIONSHIP)

HOME PHONE: (_____)_____ OTHER PHONE: (_____)_____

PARTICIPANT'S DOCTOR: _____

TELEPHONE NUMBER: (_____)_____ SEIZURES: _____YES _____NO

(IF "YES" PLEASE STATE HOW OFTEN AND WHAT TYPE USUALLY OCCUR): _____

PRESCRIBED MEDICATIONS: _____

OTHER MEDICAL CONDITIONS (PLEASE DESCRIBE, I.E. DIABETES, ALLERGIES, ETC.):
_____

PHYSICAL OR DEVELOPMENTAL DISABILITIES (PLEASE DESCRIBE):
_____

ANY OTHER INSTRUCTIONS OR PRECAUTIONS:
_____

SIGNATURE OF PARENT(S) / LEGAL GUARDIAN(S):

(SIGNATURE) (PRINTED NAME) (DATE)