



Los Robles Hospital Volunteers, Inc.
 215 W Janss Road, Thousand Oaks, CA 91360
 805 370-4685

Student Volunteer Application
 PLEASE PRINT CLEARLY

NAME
D.O.B.
DATE RCVD

NAME LAST FIRST Nickname (as you would like it on your badge) M — F

STREET ADDRESS CITY ZIP

HOME PHONE No. (include area code) CELL PHONE No. (include area code) E-MAIL ADDRESS

HIGH SCHOOL CURRENTLY ATTENDING HAVE YOU BEEN CONVICTED OF A FELONY -- OR A MISDEMEANOR

BIRTH DATE GRADE YEAR OF HS GRADUATION

PARENTS/GUARDIANS:

MOTHER'S NAME OCCUPATION DAYTIME PHONE#

FATHER'S NAME OCCUPATION DAYTIME PHONE#

PHYSICAL & MEDICAL BACKGROUND

Do you have any physical condition or disability which may limit your ability to perform any Voluntary duties?

AUTHORIZATION TO CONSENT TO TREATMENT OF A MINOR

(I) (We), the undersigned, parent(s) or legal guardians of _____ a minor, do hereby authorize and consent to a Background Investigation, TB screening and any x-ray examination, anesthetic, or surgical diagnosis rendered under the general or special supervision of any member of the Medical Staff and Emergency Room staff licensed under the provisions of the Medical Practice Act, or a dentist licensed under the provisions of the Dental Practice Act, and on the staff of any acute general hospital holding a current license to operate a hospital from the State of California Department of Public Health. It is understood that this authorization is given in advance of any specific diagnosis, treatment, or hospital care being required, but is given to provide authority and power to render care which the aforementioned physician, in the exercise of his/her best judgement, may deem advisable. It is understood that every effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached. I also understand that my child needs to have a mandatory yearly flu shot. This authorization is given pursuant to the provision of Section 25.8 of the Civil Code of California.

SIGNATURE OF PARENT/GUARDIAN PHONE No. (include area code) DATE

CONSENT TO PARTICIPATE:

This will authorize _____ a minor, to participate in such volunteer activities at Los Robles Hospital & Medical Center as may, from time to time, be prescribed by the hospital's Director of Community Services or the designated representative.

We release Los Robles Hospital & Medical Center from any claim or liability for any injury or illness resulting to said minor, not occasioned by any fault or neglect on the part of the hospital, while participating in such volunteer activities.

SIGNATURE OF PARENT/GUARDIAN PHONE No. (include area code) DATE