Los Robles Hospital Volunteers, Inc.

215 W Janss Road, Thousand Oaks, CA 91360
805 370-4685

Student Volunteer Application

PLEASE PRINT CLEARLY

Office use only
NAME
D.O.B.
DATE RCVD

☐M ☐F

LAST NAME **FIRST** **Nickname (as you would like it on your badge)**

STREET ADDRESS **CITY** **ZIP**

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

HIGH SCHOOL CURRENTLY ATTENDING

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**

REV 12/16 - mz