OPERATION HOPE - VISTA

Homeless Outreach Providing Encouragement

STUDENT VOLUNTEER QUESTIONNAIRE 2015-2016

Name _____ Date _____

Phone _____ Email _____

College _____ Major _____

Class requiring fulfillment: _____ Hours required _____

Date Hours Completed By _____ How Many Are Hours Required _____

Are you willing volunteer after you have completed requirement? _____

Will you do Overnights? _____

Operation HOPE-Vista provides educational and recreational programs to our residents (adults and/or children). For example: Job Readiness Skills, Self-Esteem Practices, Health & Fitness, Safe Living, Arts & Crafts, Group Games, etc.

What are your unique skills/talents/interests? _____

_____

_____

Would you be willing to present a program on any of the above? _____

_____

Emergency Contact Name:_____

Relationship:_____Phone #_____

Any medical issues we need to be aware of? If so, what?_____

_____

Are you taking any medications? If so what? _____

_____

Please describe your reason for choosing Operation HOPE-Vista and what you hope to gain from this experience.

_____

_____

_____

Thank you for your interest in Operation HOPE-Vista. We appreciate you!

10/2015

OPERATION HOPE - Vista
AUTHORIZATION AND RELEASE FORM

To Whom It May Concern:

I, _____, as parent/guardian of minor child,

_____, do hereby give temporary guardianship to any employee or affiliate of Operation HOPE – Vista.

This temporary guardianship includes but is not limited to authority to consent to any examination, x-ray, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by, and is rendered under the general or special supervision of any physician or surgeon licensed under the provision of Medical Practice Act on the medical staff of a licensed hospital, whether such diagnosis or treatment is rendered a the office of said physician or at a hospital.

I have read and understand the above document. By signing this document, I release Operation HOPE - Vista from any and all liability from personal injury or damage to property.

_____ _____ _____

Signature of Parent/Guardian Date Relationship to Minor

Emergency Information

Person to call first after emergency care has been authorized.

Name:_____ Cell Phone:_____

Home Phone:_____ Email:_____

Primary Doctor Name and Phone Number:_____

Medical Insurance Provider and ID Number:_____

Any Allergies to Medication/Food:_____

List Any Medication Minor Routinely Takes: (Include Name and Amount)

_____