



Youth Volunteer Application

Today's Date _____

Name _____ Age _____ Date of Birth _____

Address _____

City/State/Zip _____

Home Phone# _____ Cell # _____

Parent's or Guardian's Name _____

Parent's or Guardian's Home phone # _____

Cell Phone # _____

Email Address _____

Congregation Affiliation _____

How did you hear about Interfaith Caregivers?

Do you have any previous volunteer experience?

Area of Washington County you would like to volunteer in (Germantown, West Bend, etc.)

Other information about you, that would help to make a good placement - (education, skills, general interests, hobbies, etc.)

Please check the areas you would like to help with:

* REQUIRES ADULT SUPERVISION

- In-home Visits*
- Housekeeping*
- Snow Removal
- Lawn Mowing
- Window Washing
- Leaf Raking

Your preferences for being matched with a client...

Pets

- ___ no dogs
- ___ no cats
- ___ no birds
- ___ no pets of any kind
- ___ does not matter

Smoking

- ___ non-smoker only
- ___ does not matter

I affirm that all information on this application is correct

Signature _____

Date _____



Youth Permission Form

I acknowledge that by signing this form, I give my permission to my dependant to volunteer with Interfaith Caregivers of Washington County.

This permission form is in effect for 12 months.

Permission may be revoked within fifteen (15) days written notice to Interfaith Caregivers of Washington County.

Volunteer Name

Date

Parent/Guardian

Date

Please return permission form and application to:

*Interfaith Caregivers of Washington County
PO Box 1143
West Bend, WI 53095*



Voluntary Consent and Release

By signing below, I _____ hereby consent and **agree/disagree** that Interfaith Caregivers of Washington County may use my name, photograph or likeness, or the name, photograph or likeness of my dependant, _____, in any form of publicized material, including but not limited to newspapers, brochures, newsletters, literature, television and radio for purposes of newsworthy events or general advertising. If consent is agreed upon, I further release Interfaith Caregivers of any and all liability arising out of the use of my name, photograph or likeness, or the name, photograph or likeness of my dependant.

This consent and release is in effect for 12 months and will be reviewed again in 12 months. Permission may be revoked within fifteen (15) days of signing this release by written notice to Interfaith Caregivers of Washington County.

Name

Date

Name

Date

Please return consent and release form to:

Interfaith Caregivers of Washington County
PO Box 1143
West Bend, WI 53095