Holy Spirit
Catholic Church

LAST NAME:	
Date Received:	
Cash/Check #	

Application for Volunteer Work

VBS STUDENT VOLUNTEER

Name: _____ **Grade:** _____

Date of Birth: _____ **Age:** _____

Address: _____

City, State, ZIP: _____

Home Phone: _____ **Cell Phone:** _____

Email Address: _____

Emergency Contact Name: _____ **Cell Phone:** _____

Parishioners? (*circle one*) Yes / No **Need Service Hours for Confirmation?** (*circle one*) Yes / No

Person(s) authorized to pick up your child: _____

Previous Volunteer Experience: _____

_____

References: (Non-family members who are knowledgable of your work or service experience.)

Name: **Phone Number:**

1) _____ _____

2) _____ _____

3) _____ _____

Assignment Preference: (Please mark 1st, 2nd and 3rd choice)

Registration	
Pre-K 3	
Pre-K 4	
Kindergarten	
1st Grade	
2nd Grade	
3rd Grade	
4th Grade	

5th/6th Grade	
PE	
Music	
Arts and Crafts	
Faith	
Snacks	
Assembly	
Floater	

Submit registration to Church office, email DRE or mail:

Holy Spirit Catholic Church
11665 Ft. Caroline Road
Jacksonville, FL 32225

mhernandez@holyspiritchurchjax.org

Parent/Guardian Signature: _____ **Date:** _____

(Must complete and sign both sides)

Additional Volunteer Information and Medical Release Form

Student Volunteer Name: _____

VOLUNTEERS *will be wearing the* ***SAME BLUE VBS Staff T-SHIRTS*** *as last year*

Order a T-Shirt? Yes / No (T-Shirts: $7.00 each) **Have a shirt from last year?** Y / N

If Yes, indicate size: Youth X-Large Adult size - Small/Medium/Large/XL $7 x _____ = **Total $** _____

MEDICAL RELEASE: I hereby warrant that to the best of my knowledge, my child is in good health, and I assume all responsibility for the health of my child.

(If the following statements pertaining to medical matters for your child, sign only in accordance with your wishes)

EMERGENCY MEDICAL TREATMENT: In the event of an emergency, I hereby give permission to the physician, Holy Spirit Catholic Church and the Diocese of St. Augustine's employees, volunteer, or representatives to seek medical treatment for my child above named.

In the event that I cannot be reached in an emergency, I hereby give permission to the physician selected by the Diocesan representatives or volunteers to hospitalize, secure proper treatment for, and to order injection and/or anesthesia and/or surgery for my child named on this form.

Medications, Allergies, Physical Disabilities or Comments:

_____ _____

Family Doctor Phone Family Health Plan Policy Number

Other Medical Treatment : In the event it comes to the attention of the Diocese of St. Augustine's employees, volunteers or representatives that my child becomes ill with symptoms such as headache, vomiting, sore throat, fever or diarrhea, I hereby give permission for over-the-counter medication to be administered to my child per directions.

Eligibility to Participate: The child listed above is eligible to participate in this parish-sponsored event under the guidance and supervision of employees/volunteers from Holy Spirit Parish. If you would like your child to participate in this event, please read, complete, sign and return this form which includes your consent, as well as a full release of liability. As parent or legal guardian, you remain fully responsible for any acts of the named child during this activity.

For, and in consideration of, the child being allowed to participate in this event, and other valuable consideration, the undersigned parent, guardian or legal representative, on behalf of the child and the child's parents, personal representatives, assigns, heirs and next of kin, does hereby release and hold harmless the Diocese of St. Augustine, Bishop Felipe J. Estévez, S.T. D., as bishop of the Diocese of St. Augustine, a corporation sole, Bishop Felipe J. Estévez, S.T. D., , individually , the above noted parish, and employees and agents of said parties engaged in this particular event, their personal representatives or assigns, from any loss or damage on account of any injury to the person or the personal property, of the child, or death, caused by negligence or otherwise, while the child is engaged in the above-stated event. The undersigned expressly agrees that this release, waiver and indemnity agreement is intended to be a broad and inclusive as permitted by the laws of the State Of Florida, and that if any portion of this Agreement is held invalid, it is agreed that the balance shall; notwithstanding, continue in full legal force and effect.

The undersigned parent, guardian, legal representative further acknowledges that he/she is authorized to enter this Agreement on behalf of the child, and the child's parents, personal representatives, assigns, heirs, and next of kin.

Parent/Guardian Signature: _____ **Date:** _____


DIOCESE OF
St Augustine
Celebrating 150 Years
So That They May All Be One