Schlow Centre Region Library

Parent/Guardian Consent Form

Name of Volunteer Applicant:________________________________

Birthdate:____

Parent/Guardian Information

1. Parent/Guardian Name:_________________ Home Address:_________________

   Home/Cell phone:____________________ Work phone:___________________

2. Parent/Guardian Name:_________________ Home Address:_________________

   Home/Cell phone:_____________________ Work phone:__________________

Emergency Contacts

If parents/guardians cannot be reached, the library will contact the people listed below. These should be responsible individuals who can: 1) give permission to administer health care, 2) pick up your child if the child is ill, 3) have authority to speak on behalf of the parents/guardians.

Name:____________________________ Name:______________________________
Home/Cell phone:___________________ Home/Cell phone:____________________
Work phone:________________________ Work phone:________________________
Relationship:_______________________ Relationship:________________________

Does the child have any medical conditions that library staff should be aware of? If so, please describe:____
____

I understand that in the case of a medical emergency, every effort will be made to reach one of the people listed above. If none of the people can be contacted, I authorize library staff to give consent to medical treatment for my child as deemed necessary by emergency personnel.

Print Name of Parent/Guardian:__________________________________

Signature of Parent/Guardian:__________________________________ Date:______