



VOLUNTEER APPLICATION

Name: _____ Date: _____

Address: _____

City, State, Zip: _____

Phone: (Home) _____ (Cell) _____

(Work) _____

Email: _____

Parent/Guardian Name (if under 18): _____

Parent/Guardian Phone: _____

Where did you hear about TAASC? _____

Do you have experience with people with disabilities? YES NO If yes, please describe:

Check the sport/sports do you are interested in volunteering in and describe your experience.

Sport	Experience	Level/Certifications
Alpine Skiing		
Cycling		
Ice Skating		
Hockey/Sled Hockey		
Kayaking/Canoeing		
Sailing		
Water Skiing/Boating		

Do you have First Aid, CPR or any other relevant certifications? _____

Emergency Information

Person to Notify: _____ Relationship: _____

Phone: (Home/Work) _____ (Cell) _____

Insurance Company: _____ Policy #: _____

Do you take any medications or have any conditions that might impact your volunteer work? Please explain. _____

Have you ever experienced any of the following?

Allergy to bee stings Balance Problems Seizures

Allergy to Penicillin Diabetes/Low Blood Sugar Asthma

Allergy to other medication: _____

Describe any actions to be taken in response to these (location of medications, etc.) _____

Consent for Treatment

I hereby give my consent for the emergency medical treatment of _____
at _____ hospital or emergency facility.

Printed Name: _____

Self/Parent/Legal Guardian Signature Date: _____

Non-Consent for Treatment

I do not give my consent for emergency medical treatment for myself/my child/my ward. In the event of illness or injury I wish TAASC to take the following actions:

Printed Name: _____

Self/Parent/Legal Guardian Signature Date: _____