Trinity Health System
Teen Volunteer Application

NAME_____DATE_____
(Last) (First)

ADDERSS_____CITY_____STATE_____

AGE_____DATE OF BIRTH_____HOME PHONE_____

CONTACT IN CASE OF EMERGENCY:

_____
(Name) (Relationship) (Home Phone)

NAME OF SCHOOL_____GRADE 9 10 11 12

GRADUATION YEAR_____CAREER INTEREST_____

PLEASE INDICATE IF YOU PREFER TRINITY EAST ____WEST_____BOTH_____

VOLUNTEER EXPERIENCE_____

INTEREST, SKILLS, SCHOOL ACTIVITIES_____
_____

FAMILIY PHYSICIAN_____PHONE_____

LIMITATIONS RELATED TO HEALTH_____

REFERENCE: Please choose your references from among the following: family physician, teacher, minister, principal, employer, adult volunteer here

1. Name_____Phone_____
   Address_____ City_____State_____Zip___
2. Name_____Phone_____
   Address_____City_____State_____Zip___

I want to volunteer:___Summers only___Year round___Limited School_____
I would like to volunteer at Trinity East____ Trinity West_____Both_____

Applicant's Signature_____Date_____

Parents Signature_____Date_____
Your signature indicated your approval for your child's participation in the teen volunteer program, your acknowledgement that he or she is in good health.

Opportunities for volunteers are provided without regard to religion, creed, race, national origin, age, or sex.