COOPER UNIVERSITY HOSPITAL VOLUNTEER PROGRAM

CONSENT FORM

CONFIDENTIAL

PARENTAL CONSENT for-(name) _____. I authorize the release of information from my son/daughter's school records to the Volunteer Services Department of The Cooper Health System.

Parent or Guardian Signature_____Date_____

Dear Counselor or Teacher:
Each student who applies for volunteer work must have a recommendation from school. We would appreciate your evaluation and comments to help us choose candidates who will best benefit from our program and serve our organization and our patients. This information will be kept confidential. Please complete and return to me at the above address. Thank you for your assistance.

Eileen Baptiste, Volunteer Coordinator, /Pastoral Care

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1. Is the applicant 14 years of age or older? _____
2. What grade is the applicant in? _____
3. How long have you know the applicant? _____
4. Is the applicant reliable? _____
5. Is the applicant mature? _____
6. Can the applicant follow directions? _____
7. Is the applicant courteous? _____
8. Does the applicant take initiative? _____
9. Does the applicant have any special qualifications which would help us when making assignments?_____
   _____

Name _____Signature_____
(Please print or type)

Title _____School _____Date _____

Contact: Volunteer Coordinator
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