

AUTHORIZATION FOR MINOR’S VOLUNTEER SERVICES

By my signature below, I give my permission for _____
to serve as a volunteer at Newton-Wellesley Hospital (“NWH”).

If in the course of his/her volunteer services, _____ requires
emergency treatment, I consent to such treatment as deemed necessary by NWH.

Our family physician is: _____

He/she is located at: _____

And the telephone number _____

In the event I cannot be reached, I authorize NWH to contact the following person and to release
such information as necessary to obtain his/her assistance:

Name: _____ Relationship: _____

Address: _____

Telephone Number: _____

By checking this box, I give permission for my child to have a **criminal background check** (CORI) conducted by NWH for volunteer placement.

By checking this box, I hereby authorize the use and reproduction by Newton-Wellesley Hospital of any and all photographs or video taken of my child for the purpose of general marketing communications, promotion or advertising, without compensation to my child. All photographs and video shall constitute the property of Newton-Wellesley Hospital.

Print Name of **Parent** or **Guardian**
(Please circle relationship)

Signature of Parent or Guardian	Date
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Address

Telephone Number

Please direct any questions to NWH’s Volunteer Services Department, at (617) 243-6048