



## VOLUNTEER CONTACT INFORMATION

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email Address: \_\_\_\_\_

Shirt Size: \_\_\_\_\_

Volunteer Sign-up:

Saturday, June 25, 2011 – Registration – 4PM – 10PM – Fletcher Park, San Marco

Please return form to Amy R. Davis, Development Officer, Community Hospice Foundation, 4266 Sunbeam Road, Jacksonville, FL 32257 or [adavis@communityhospice.com](mailto:adavis@communityhospice.com).

Volunteer t-shirts will be available for pick-up on June 23 and 24 from 8 a.m. – 4:30 p.m. at the Hadlow Center for Caring, Foundation Office, 4266 Sunbeam Road.

If you are under the age of 18 the parental consent form on the back must be completed.  
Thank you for your support!

COMMUNITY HOSPICE OF NORTHEAST FLORIDA  
**YOUTH VOLUNTEER PARENTAL CONSENT FORM**

Parent or Guardian Name: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

I, the undersigned (parent/guardian) give my permission to allow  
\_\_\_\_\_ to volunteer with Community Hospice of Northeast Florida.  
Student Name

I am aware that he/she will be volunteering with hospice patients and will be under the supervision of a Volunteer Program Specialist and bound by a statement of confidentiality. I am also aware that he/she will have to have a baseline and an annual Tuberculosis screening (PPD).

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

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Student Name: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Grade this school year: \_\_\_\_\_

Name of School: \_\_\_\_\_

School Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

Faculty Sponsor: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date

Office Use: Comments:

\_\_\_\_\_

\_\_\_\_\_

Volunteer Program Specialist