Office Use Only: Current Application ☐ Background Check ☐ Exp. Date_____

2023-24 Volunteer Application

Name: _____

Address:

_____

City, State, and Zip Code:

_____

Phone Number(s)

_____

E-mail Address:

_____

Are you 18 years or older? Yes No
*(*IF YES, YOU MUST COMPLETE A BACKGROUND CHECK)*

Circle your choices below:
Grade level(s) preferred: K 1st 2nd 3rd 4th 5th 6th

Please let us know what days and times you are available to volunteer:

_____

_____

Current Profession: ***(If retired or not working, please list previous occupation)***

_____
Special Skills, Interests or Hobbies:

_____

Emergency Information
Name and phone number of person to be notified in case of an accident or emergency.

_____

Emergency Source of Medical Care

Should we need to take you to the emergency room or hospital for treatment:

Preferred Hospital: _____

Conditions we should know about in case of an emergency (asthma, diabetes, allergies, etc.) Please describe: _____

_____

Agreement and Signature

I certify that my answers are true and complete to the best of my knowledge.

I have read a Summary of the Tennessee State Department Childcare Rules and Regulations and have read and received a copy of the Gentry's Educational Foundation Volunteer Handbook. I agree to abide by both documents at all times.

I understand that as a volunteer, I will not be left alone with a student(s) at any time and that if I am over the age of 18, I am required to complete a background check in order to tutor with GEF.

In the event of an emergency and my emergency contacts cannot be reached, I give permission to Gentry's Educational Foundation personnel to obtain whatever medical treatment they deem necessary for me. I waive release and hold harmless Gentry's Educational Foundation, their employees and agents from all legal and financial responsibility and from all costs, injuries and/or other damages which might occur from the decision to provide medical treatment to me and from the choice of the provider of the medical treatment by Gentry's personnel. I authorize the use and disclosure of my health information for purposes of securing medical treatment.

Name _____ **Date**_____

Parent Signature **(if under 18 years old)**_____