VOLUNTEER REGISTRATION FORM

VOLUNTEER INFORMATION			
First Name:	Middle Initial:	Last Name:	
Address:			
City:	State:	Zip:	
Home Phone:	Other Phone Number:		
Email Address:			
Date of Birth:	Sex: ❑ M ❑ F ❑ Prefer not to answer ❑ Other		
(If applicable) Military Service: ❑ Active Military Duty ❑ Reserve ❑ Veteran ❑ N/A	Years of Service:		
(If applicable) Branch of Service:	Rank:		
PARENT/LEGAL GUARDIAN INFORMATION (IF VOLUNTEER IS A MINOR)			
First Name:	Last Name:		
Address (if different than above):			
City:	State:	Zip:	
Home Phone:	Mobile:	Work:	
Email Address:			
EMERGENCY CONTACT			
First Name:	Last Name:		
Relationship to Participant:			
Home Phone:	Mobile:	Work:	
DISABILITY INFORMATION (if applicable):			
Disability/Diagnosis:			
Date of injury or onset:	Do you use any assistive devices? (wheelchairs, prosthetics, crutches, communication devices, etc.)		
If you use a wheelchair, do you need assistance with transfers? ❑ Y ❑ N			
MEDICAL INFORMATION			
Are you currently taking any medications? ❑ Y ❑ N *If YES, please list medication type and reason:*			

Do you have any dietary restrictions? ❑ Y ❑ N *If YES, please list:*

Do you have any allergies? (latex, medication, insects, food) ❑ Y ❑ N *If YES, please list:*

Do you have a history of seizures? ❑ Y ❑ N *If YES, please list type, frequency, date of last seizure:*

Have you had surgery in the last six months? ❑ Y ❑ N *If YES, please explain:*

PLEASE INDICATE YES OR NO TO EACH QUESTION. IF YES, PLEASE DESCRIBE TYPE, FREQUENCY, AND SEVERITY		
Brain Injury	❑ Y ❑ N	
Post-Traumatic Stress	❑ Y ❑ N	
Blind or low vision	❑ Y ❑ N	
Deaf or hard of hearing	❑ Y ❑ N	
Limited range of motion in any limbs	❑ Y ❑ N	
Difficulty with balance	❑ Y ❑ N	
Spinal stabilization devices	❑ Y ❑ N	
Paralysis (please indicate body part)	❑ Y ❑ N	
Sensitivity to hot or cold	❑ Y ❑ N	
Difficulty speaking or communicating	❑ Y ❑ N	
Difficulty remembering or following directions	❑ Y ❑ N	
Emotional and/or behavioral concerns we should know about	❑ Y ❑ N	
Personal care or independence concerns	❑ Y ❑ N	
Cognitive or developmental delay	❑ Y ❑ N	

<table>
<tr><td>Heart/Cardiac condition</td><td colspan="2">❑ Y ❑ N</td><td colspan="2"></td></tr>
<tr><td>Respiratory condition</td><td colspan="2">❑ Y ❑ N</td><td colspan="2"></td></tr>
<tr><td colspan="5">Please list any other medical conditions or concerns that may affect your ability to volunteer:</td></tr>
<tr><td colspan="5">TRAININGS/CERTIFICATIONS (Please provide proof of certifications)</td></tr>
<tr><td colspan="2">First Aid/CPR: ❑ Y ❑ N</td><td colspan="3">Expiration Date:</td></tr>
<tr><td>Child Abuse/Sexual Molestation
Training: ❑ Y ❑ N</td><td colspan="3">Type (SafeSport, Darkness to Light, etc):</td><td>Expiration Date:</td></tr>
<tr><td colspan="5">Additional Certifications (coaching, sport-specific, etc):</td></tr>
<tr><td colspan="5">SPORT/ADMINISTRATIVE BACKGROUND:</td></tr>
<tr><td colspan="5">Please describe you sport and/or administrative background:</td></tr>
<tr><td colspan="5">Why would you like to volunteer for CHAPTER NAME?</td></tr>
<tr><td colspan="5">What are your short and long terms goals while working at CHAPTER NAME?</td></tr>
<tr><td colspan="5">What role do you think you would be most helpful in? (coach, administration staff, etc.)</td></tr>
<tr><td colspan="5">Please provide any additional information that will help us create a successful experience for you:</td></tr>
</table>

How often are you looking to volunteer? ______________ # of hours	
Which days of the week would you like to volunteer? (circle each day) M T W Th F S Sun	
CURRENT EMPLOYER	
Company/Organization:	
Employer Contact First Name:	Employer Contact Last Name:
Phone Number:	Email Address:
REFERENCE #1:	
First Name:	Last Name:
Company/Organization:	Relationship to Volunteer:
Email Address:	Phone Number:
REFERENCE #2:	
First Name:	Last Name:
Company/Organization:	Relationship to Volunteer:
Email Address:	Phone Number:
By signing below, I certify all information is accurate and truthful to the best of my knowledge.	
Printed Name:	Date:
Signature:	
If the participant is under 18 or legally dependent, this section must also be completed:	
Parent/ Legal Guardian Printed Name:	Date:
Parent/Legal Guardian Signature:	Relationship: