Group #_____

VOLUNTEER STATEMENT AND REGISTRATION FORM

Give to center staff upon arrival.

Must be received by staff prior to volunteer participation in ASP activity

Appalachia Service Project (ASP) is a home repair and housing rehabilitation ministry. ASP operates in rural areas and cannot guarantee the safety or sanitation of its work sites, accommodations, and facilities. Volunteers will be participating in home repair and home building activities including, but not limited to: roofing, carpentry, dry wall installation, building steps, plumbing, glasswork, insulating, painting, flooring, masonry, electrical wiring and other home repair, remodeling and renovation. These activities include, but are not limited to: the use of power tools such as saws and drills, as well as the use of hand tools. The foregoing activities will also require climbing with and without supplies, tools and materials as well as working in high places such as on roofs and other facets of construction work. All volunteers, as well as these volunteers and their parent(s)/legal guardian(s), must have read, be familiar with, and abide by ASP's Safety Manual and Expectations, Rules and Regulations. The minimum age for ASP volunteers is 14; however, 13 year old volunteers may participate if they have completed the 8th grade. Volunteers may engage in non-sponsored activities including, but not limited to: hiking, swimming, basketball, volleyball, baseball, football, Frisbee, or other sports activities of their choosing. Planned evening activities may include, but are not limited to: visiting strip mines, traveling to visit places or people of regional interest. Volunteers are not required to engage in any work or recreational activity in which they feel they are not able to safely participate.

I give permission for treatment by competent medical personnel as a result of accident or medical emergency while involved in the activities of ASP. Consent is given to accompanying adult volunteers on this trip to hospitalize, secure proper treatment and to order injections, anesthesia, or surgery by qualified medical personnel. If possible, the adult contact will make the final decision in cooperation with medical personnel. As ASP does not carry accident or medical insurance on volunteers, I agree that my insurance company will be used for such medical care expenses and I am aware that I may be billed by the medical provider for any medical treatment expenses not covered by my insurance. I understand that if I do not have medical insurance coverage that I am responsible for the payment of any medical bills.

The foregoing statement of activities and the Appalachia Service Project information and guidelines (specifically ASP's Expectations, Rules, and Regulations and ASP's Safety Manual) have been read and the extent and nature of the activities in which you or your youth will participate are understood. If this Release is for a volunteer under the age of 18, the parent/legal guardian's signature below demonstrates that the parent/legal guardian has read this Release, the ASP guidelines and manuals, and hereby gives his/her consent to allow the volunteer to participate in the activities outlined above and release Appalachia Service Project, Inc., its agents, employees and any and all persons connected therewith are hereby released and discharged from any and all liability, claims, and causes of action of any type whatsoever arising out of or in any way connected with participation in the activities of the Appalachia Service Project, Inc.

Media Release and Waiver

The Volunteer and the Guardian grant and convey to ASP all right, title and interest in any and all photographic images and video or audio records made during the Participant's participation with Appalachia Service Project. The Volunteer and Guardian also hereby grant permission for ASP to use photographs, videos, audio recordings, or to otherwise document Volunteer's participation in ASP programs, solely for the purpose of marketing, research and/or education. ASP will not identify by name any minors in either print or web-based images.

Volunteers 18 years of age or older:

Participated with ASP before? Yes No

_____
Printed name of participant

_____
Signature Date

Volunteers under age 18 years of age:

Participated with ASP before? Yes No

_____
Printed name of participant

_____
Signature Date

_____
Parent/Legal Guardian Signature Date

NOTARY REQUIRED: SIGN ABOVE IN PRESENCE OF NOTARY

_____, appeared before me
Name of participant (18 years & older) **OR** name of parent/guardian of minor participant

_____, a Notary Public of _____ County in the State of _____,
(Notary's name) (County)

the person whose signature appears above and with whom I am personally acquainted or proved to me on the basis of satisfactory evidence and acknowledge that he/she executed the instrument for the purposes therein contained.

Witness my hand and official seal this _____ day of _____, 201 _____.

_____ My commission expires: _____
(Notary Public)

VOLUNTEER INFORMATION

Last Name _____ Marital Status **single** **married** **widowed** **divorced**

First Name _____ MI ____ Birthday _____ **(mm/dd/yy)**

Nickname _____ Gender **Male** **Female**

Address _____ Occupation _____

City, State, Zip _____ Email _____

Phone _____

EMERGENCY MEDICAL INFORMATION

*Medical information on this form will **only** be used if medical treatment is needed. It will be used for no other purpose.*

Social Security # _____ (optional) Date of last Tetanus shot _____

Medication(s) you currently take (prescribed & over-the-counter – please list all – this is extremely important!!)

_____

_____

Medication(s) you **CANNOT** take _____

Any allergies &/or special health problems or concerns _____

_____

Medical insurance information:

Company name _____ Policy # _____

Phone _____ Policy Holder's ID # _____

Address _____ Relationship to policyholder _____

City, State Zip _____

PLEASE INCLUDE A COPY OF YOUR INSURANCE CARD WITH THIS DOCUMENT

In an emergency, please contact:

Name _____ Name _____

Relationship _____ Relationship _____

Address _____ Address _____

City, State Zip _____ City, State Zip _____

Day Phone _____ Day Phone _____

Evening Phone _____ Evening Phone _____

Cell Phone _____ Cell Phone _____

Also on ASP? Yes No Also on ASP? Yes No

Physician information:

Physician name _____ Phone _____

In the event of an emergency or non-emergency situation in which medical treatment is required as a result of participation with Appalachia Service Project, Inc., every reasonable effort will be made to contact the persons listed above. If unsuccessful in contacting the persons listed, consent/permission is given for treatment by competent medical personnel.