YOUTH VOLUNTEER APPLICATION

YOUTH INFORMATION

Name			Date
Address		City & State	Zip Code
Home Phone	Youth Cell Phone	Youth Email Address	
School		Grade	Age/ Birthdate

PARENT INFORMATION

Parent/Guardian 1 Name			
Address		City & State	Zip Code
Home Phone	Cell Phone	Email Address	
Parent/Guardian 2 Name			
Address		City & State	Zip Code
Home Phone	Cell Phone	Email Address	

Our kitchen is located at AuerFarm (158 Auer Farm Road, Bloomfield, CT) and is currently open on Wednesdays and Thursdays. Wednesday shifts are 3-6pm (cooking). On Thursdays the shift is from 3-5:00pm (packaging).

You must be able to work at least a 2.5 – 3 hours shift to volunteer at Healing Meals. What days and times are you able to volunteer?

Wednesday: _____ Thursday: _____

What date can you start volunteering: _____

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How did you hear about Healing Meals Community Project?

- ☐ Friends or family
- ☐ Heard/read about in on Facebook/ TV/ Newspaper/ Radio
- ☐ School
- ☐ Other: _____

What motivated you to volunteer? Check all that apply.

- ☐ To learn about healthy foods
- ☐ A friend or family member was sick and helped by Healing Meals
- ☐ I have been through a serious illness or had cancer
- ☐ I received meals from Healing Meals
- ☐ My friend works/volunteers at Healing Meals
- ☐ My parents want me to volunteer
- ☐ School/ religious organization requires community service hours
- ☐ I want to help people
- ☐ I wanted to be more involved in my community
- ☐ I want to learn to cook
- ☐ Other: _____

What would you like to learn? Check all that apply.

- ☐ About healthy foods
- ☐ How to cook
- ☐ Different cooking skills – like knife skills
- ☐ Why food makes a difference in health
- ☐ Other: _____

Are you interested in learning more about the role of food (both eating and producing/ distributing food) in issues like health care, the environment, and global climate change? ☐ Yes ☐ No

Is there anything else you want us to know?

_____

_____

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DEMOGRAPHIC INFORMATION

This information is confidential. Our funders are interested in knowing the demographic makeup of our volunteers. Participation is optional and will be used to describe our volunteers as a group and not individually. Thank you for your participation.

Racial/ Ethnic:

- ☐ African American
- ☐ Asian/ Pacific Islander
- ☐ Caucasian
- ☐ Hispanic/ Latino
- ☐ Native American
- ☐ Other

Gender: ☐ Female ☐ Male ☐ Other: _____

VOLUNTEER COMMITMENTS

Thank you for volunteering with Healing Meals Community Project. We are committed to providing you, as a Healing Meals volunteer, with a rich experience and in finding a volunteer position that meets Healing Meals' needs and is a good fit for you.

- ☐ As a Youth Volunteer at Healing Meals, I agree to participate fully in the Healing Meals **culture**, which includes working as a team, being open and friendly and inclusive of others, and being fully present and positive on my shift.
- ☐ I agree to let Healing Meals Community Project know at least **48 hours ahead** of time if I am not able to attend a scheduled shift.
- ☐ I agree that I will communicate, as needed, to the Volunteer Coordinator in regards to any volunteer responsibilities. This is my responsibility not the responsibility of my parent/guardian.
- ☐ I understand that the **third time** I do not show up or provide at least 48 hours notice, I will not be allowed to participate in the program.
- ☐ I agree to keep **confidential** all information about Healing Meals' clients.

Volunteer Signature Date

Parent Signature Date

For office use:

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VOLUNTEER AGREEMENT & RELEASE FROM LIABILITY

1. I, _____, agree to work for Healing Meals Community Project as a volunteer.
2. As a volunteer, I understand that I control the dates and times when I do the work, and that Healing Meals Community Project is not responsible for scheduling my volunteer work. I also understand I will not be compensated for anytime spend volunteering, nor am I entitled to benefits, including employment insurance benefits upon the termination of this agreement or as a result of this service.
3. I am aware that participate as a volunteer may require periods of standing, lifting and carrying up to 40 pounds and will require the exercise of reasonable care to avoid injury. I am voluntarily participating in this activity with knowledge of the hazards and potential dangers involved, and agree to accept any and all risks of personal injury and property damage.
4. As consideration for volunteering for Healing Meals Community Project, I hereby agree that I, and my assignees, heirs, guardians, and legal representatives, will not make a claim against Healing Meals Community Project or its employees, agents or contractors for injury or damage resulting from the negligence, whether active or passive, or other acts, however caused, by any of its officers, employees, agents, or contractors of Healing Meals Community Project and its offices, employees, agents and contractors from all actions, claims, or demands that I, my heirs, guardians, and legal representatives now have, or may have in the future, for injury or damage resulting from my participation in the project.
5. I understand that if I am injured in the course of the project, I am not covered by Healing Meals Community Project's insurance. I authorize Healing Meals Community Project to seek emergency medical treatment on my behalf in case of injury, accident or illness to me arising from my involvement as a volunteer. I understand that I will be response for medical costs incurred by such accident, illness or injury.
6. I understand that the materials and tools provided by Healing Meals Community Project are and remain the property of Healing Meals Community Project, and I agree to return these tools and any remaining materials to Healing Meals Community Project at the end of my volunteer service.
7. I have carefully read this agreement and fully understand its contents. I am aware that this is a release of liability and sign it of my own free will.

Volunteer Signature	Healing Meals Community Project Representative Signature
Print Name	Print Name
Date	Date

If volunteer is under 18 years of age, parent or guardian must read and sign. This release, its significance, and assumption of risk have been explained to and are understood by the minor.

Parent or Guardian Signature

Print Name

Date

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PHOTO RELEASE

As a non-profit social benefit organization, Healing Meals Community Project depends on donations from individuals, businesses, organizations and foundations to support our work. Sharing stories about our programs and their impact is vital to our ability to raise funds. We ask for your partnership in this effort by signing the following photo release.

Video, Photographic, Internet Release Agreement

The undersigned enters into this agreement with Healing Meals Community Project. I have been informed and understand that Healing Meals Community Project may wish to use my own and/or my child's first name, likeness and speech in its printed and/or electronic communication materials (brochures, videos, websites, social media, etc.)

I grant Healing Meals Community Project and its designees the right to use such images and information. This grant includes the right to edit, mix or duplicate and to use or re-use the images in whole or in part and in any manner as Healing Meals Community Project in its sole discretion may elect. Healing Meals Community Project or its designee shall have complete ownership of the images and any printed materials, video programs and web content (i.e. material accessible over the internet) in which images may appear.

I also grant the right to broadcast, exhibit and otherwise distribute images as well as printed materials, video programs and/or web content either in the whole or in part, and either along of with other products.

I confirm that I have the right to enter into this Agreement; that I am not restricted by any other commitments to third parties; and that Healing Meals Community Project has no financial commitment or obligations to me as a result of this agreement.

I hereby give all clearances, copyright and otherwise, for the use of such images, and I expressly release Healing Meals Community Project and its officers, employees, agents and designees from any and all claims known or unknown arising out of or in any way connected with the above uses and representations.

The rights granted Healing Meals Community Project herein are perpetual. I hereby acknowledge receipt of reasonable and fair consideration.

Print Parent/ Guardian's Name	Print Youth's Name
Parent/ Guardian's Signature	☐ No, I would like myself and/or my child to opt out of the Photo release.
Date	This release will supersede any previous releases on file.

EMERGENCY MEDICAL RELEASE FORM

This form is required for participation in the Healing Meals Community Project. Please complete each section thoroughly, sign and date.

Youth's Name	Birthdate
Sex: ☐ Female ☐ Male	Age

Mother's Name

Home Phone	Cell Phone	Work Phone

Father's Name

Home Phone	Cell Phone	Work Phone

Additional person authorized to pick up my child and/or to contact in case of an illness or an emergency:

Name	Relationship	Phone

Allergies – does your child have any allergies to food, medications, insects, etc.? ☐ Yes ☐No

If yes, please list above and include protocol.

Health Conditions – does your child currently or in the past have any medical conditions that we may need to know about that would impact their work in the kitchen, or in the case she/he needs treatment?
☐ Yes ☐No

If yes, please list above.

List any medication(s) currently taken by your child and include protocol.

EMERGENCY MEDICAL RELEASE FORM (Continued)

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Name of Child's Physician: Phone:

Insurance Company Policy #/ Medical #

In case of an emergency, take my child to the following hospital (please check one):

☐ Nearest hospital OR ☐ _____ (name of hospital)

Emergency Release:

If, in the judgment of the staff of the Healing Meals Community Project, the child named above needs immediate care and treatment as a result of any injury or sickness, I hereby give permission to the staff to secure proper treatment for my child. I do hereby consent to whatever x-ray, examination, anesthetic, medical, surgical or dental diagnosis or treatment and hospital care are considered necessary in the best judgment of the attending physician, surgeon or dentist and performed by or under the supervision of the medical staff of the hospital or facility furnishing medical or dental services. It is further understood that the undersigned will assume full responsibility for any such action, including payment of costs I do hereby agree to indemnify and hold harmless the Healing Meals Community Project (including its officers, directors, staff members and/or volunteers) from any claim by any person whomsoever on account of such care and treatment of said child.

Print Parent/ Guardian's Name

Parent/ Guardian's Signature

Date