



**I realize all of the positions require a five day commitment the week of VBS. I will attend one meeting before VBS, in June in the Parish Center, date to be determined.**

**NO CELL PHONES ALLOWED DURING VBS HOURS,  
CELL PHONES WILL BE COLLECTED DAILY.**

Signature of Teen Volunteer \_\_\_\_\_

T-Shirt Size: **Youth** - M L or **Adult** - S M L XL XXL

Cost of T-Shirt + snacks is \$15.00 Paid Cash \_\_\_\_\_ Paid Check \_\_\_\_\_

Make checks payable to St. Mark.

### Teen Emergency Contact and Medical Information

Parent 1: \_\_\_\_\_  
Last Name First Name

Parent's Home# \_\_\_\_\_ Email \_\_\_\_\_

Cell# \_\_\_\_\_ Work# \_\_\_\_\_

Parent 2: \_\_\_\_\_  
Last Name First Name

Parent's Home# \_\_\_\_\_ Email \_\_\_\_\_

Cell# \_\_\_\_\_ Work# \_\_\_\_\_

Medical Insurer \_\_\_\_\_

Policy# \_\_\_\_\_ Group# \_\_\_\_\_

Medical Conditions \_\_\_\_\_

Allergies \_\_\_\_\_ Drug Allergies \_\_\_\_\_ Asthma \_\_\_\_\_

Current Medications \_\_\_\_\_

Special Needs \_\_\_\_\_

#### WAIVER/AUTHORIZATION FOR EMERGENCY MEDICAL ATTENTION

I, who by law may do so, authorize the administration of emergency medical treatment for the subject of this release form. I understand that all reasonable safety precautions will be taken during this event. I will not hold St. Mark the Evangelist Catholic Church, members of the staff or volunteers responsible for accidental harm or injury that may occur during this event. I understand that, in the event medical intervention is needed, every attempt will be made to contact the person(s) listed on this form immediately.

\_\_\_\_\_  
Parent Signature is required

\_\_\_\_\_  
Date