Lakeridge Health

Parent/Guardian Consent to Volunteer (under 18 years)

Please type the full name of the applicant who is 15-17 years of age:

Are there any restrictions or limitations we should be aware of (physical or other)? If so, how can we help?

☐ None ☐ Hearing ☐ Vision ☐ Pushing wheelchair with person ☐ Walking ☐ Standing

☐ Other (Please briefly explain):

By typing your full name below you are providing consent for the applicant named above to volunteer at Lakeridge Health:

Type your full name:

Indicate your relationship to the applicant (select only one)

Parent ☐

Guardian ☐

Please provide your contact phone number:

Date: