

## Volunteer Community Service Program Application

**\*\*For students in the Town of Ithaca, Village of Lansing, Village of Cayuga Heights, and Town of Caroline\*\***

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Age: \_\_\_\_\_ Grade: \_\_\_\_\_

Youth Cell Phone: \_\_\_\_\_ Youth Email: \_\_\_\_\_ School: \_\_\_\_\_

Address: \_\_\_\_\_

Street	City or Town	Zip	Municipality
--------	--------------	-----	--------------

Parent/Guardian Name(s): \_\_\_\_\_

Parent/Guardian Email(s): \_\_\_\_\_ Home Phone: \_\_\_\_\_

Parent/Guardian Cell Phone(s): \_\_\_\_\_

---

### Which session are you applying for?

- Fall: Tuesdays October 9<sup>th</sup> – December 4<sup>th</sup> 3:30pm – 5:30pm**

### What Transportation will youth use to get to and from the meeting site (Dewitt Middle School)?

- Stay after school
- Ride with a parent/guardian
- Ride bike or walk
- Other (please specify) \_\_\_\_\_

\*If you are unable to find transportation, please contact the Learning Web for transportation assistance.

---

### Return Completed Application to Micah Wilkins

**Mail:**

Bevi Wallenstein  
The Learning Web  
515 West Seneca St.  
Ithaca, NY 14850

**Fax:**

Attn: Bevi Wallenstein  
(607) 275-0312

**Scan & email to:**

[bevi@learning-web.org](mailto:bevi@learning-web.org)

Please contact Bevi Wallenstein at (607) 275-0122 or [bevi@learning-web.org](mailto:bevi@learning-web.org) with any questions or concerns.

## Interested in The Learning Web?

Please complete this form and return with signatures to Micah Wilkins at The Learning Web. If you have any questions or concerns, please call me at 607.275.0122. *We look forward to hearing from you!*

### Students:

Name \_\_\_\_\_ Age \_\_\_\_\_ School \_\_\_\_\_

Address \_\_\_\_\_

*Phone* \_\_\_\_\_ *Parent's Name* \_\_\_\_\_ *Main Interest Area* \_\_\_\_\_

### Parents/Guardians:

#### PARTICIPATION PERMISSION

As \_\_\_\_\_'s guardian, s/he has my permission to participate in The Learning Web Program. I understand that The Learning Web is a community organization that places young people in "hands-on" learning experiences, outside of the classroom. Because these are educational apprenticeships/activities, not "jobs," \_\_\_\_\_ is not covered by Workers Compensation. I will not hold The Learning Web or community mentor liable for accidents that may occur during a career exploration tour, apprenticeship, or service project.

I also understand that \_\_\_\_\_ is covered under The Learning Web's Group Protector Policy, an accident insurance plan that pays up to \$5,000 in medical expenses over and above those bills covered by my own insurance. I understand that The Learning Web works closely with school staff and the Ithaca Youth Bureau. I give my permission for The Learning Web to share information with my child's school and with the Ithaca Youth Bureau in order for the best placement to be made.

#### PHOTO PERMISSION

On occasion we use photos of our services in publications/social media that may be sent to school staff, community members and funders who like to know about our programs and the ways youth benefit from them. If you are willing to have us use your child's name/photograph, please indicate your preference below. Please call us if you have any questions. Thanks!

#### Please check the box (s) below to indicate your response:

Yes	No	Print publications (pamphlet, newsletter, reports to funders etc.)
<input type="checkbox"/>	<input type="checkbox"/>	

Yes	No	Learning Web social media (no name, just photo)
<input type="checkbox"/>	<input type="checkbox"/>	

Please list any restrictions regarding use of photos here: \_\_\_\_\_

\_\_\_\_\_  
Youth Name (Please Print)                      Youth Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Caregiver Name (Please Print)                      Parent/Caregiver Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Caregiver Phone

\_\_\_\_\_  
Parent/Caregiver Email

### RELEASE FOR MEDICAL TREATMENT

Name of Minor \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

I, the undersigned being the parent(s) or legal guardian(s) of the above named minor, know that for the reasons stated below I may not be available to authorize medical, dental, surgical care and hospitalization. This authorization is intended to give the person or persons so named the right to give consent to authorized emergency diagnostic procedures, medical, dental, surgical care and hospitalization, that the person so designated deems advisable, and which the physician, dentist, or hospital personnel in said person's judgement may deem advisable.

I have put the important medical facts, if any, on the reverse side of this document. The medical facts are intended to help the doctor, medical personal, or other person in deciding what treatment is to be given but is in no way intended to restrict the giving of authorization or consent by the person named herein.

The reason I am giving consent and authorization is as follows:

Child is enrolled at The Learning Web Program, and I may be unable to be reached in emergency.

Names, addresses and phone numbers of those persons I am so authorizing are as follows:

Staff of The Learning Web, 515 W. Seneca St. Ithaca, NY, 275-0122

The period of time over which this authorization exists is as follows:

Beginning at 12 Midnight on October 9 2018  
MONTH DAY YEAR

Ending at 12 Midnight on December 4 2018  
MONTH DAY YEAR

It is intended that this document shall be presented to the physician, dentist, or appropriate hospital or medical representative at such time that the medical, dental, surgical care or hospitalization shall be authorized.

It is intended that this authorization relieve the physician, dentist, person rendering such care of the hospital or institution in which such care is given from any liability resulting from the failure of me, the parent or guardian of the above named minor, from signing a consent or authorization to render such care. It is the intent that the person or persons appointed herein shall be able to act in my stead in making decisions.

\_\_\_\_\_  
SIGNATURE OF PARENT/GUARDIAN

\_\_\_\_\_  
PRINT NAME OF PARENT/GUARDIAN

\_\_\_\_\_  
ADDRESS

STATE

ZIP

PHONE

DATE

**ALLERGIES**

**MEDICATIONS**

**LAST TETANUS SHOT**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical history, or other pertinent health-related facts that should be known:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

For information only, I am listing said minor's usual dentists and doctors so they may be consulted if that is deemed necessary by anyone.

Physician's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Dentist's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Parent/Caregiver Contact Information:

Parent/Caregiver Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Daytime Address \_\_\_\_\_

Parent/Caregiver Name \_\_\_\_\_ Daytime Phone \_\_\_\_\_

Daytime Address \_\_\_\_\_