theLearningWeb

Learning by doing... youth becoming adults

515 West Seneca Street, Ithaca, NY 14850 607.275.0122 www.learning-web.org

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?

☐ **Spring: Tuesdays & Thursdays, March 16th – April 27th**

What Transportation will youth use to get to/leave from the meeting site when in-person?

☐ Ride with a parent/guardian

☐ Ride bike or walk

☐ Other (please specify)___________________________

*Due to Covid-19, The Learning Web is unable to provide private transportation at this time

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Return Completed Application to Meghan Dushko by March 5th

Mail:
Meghan Dushko
The Learning Web
515 West Seneca St.
Ithaca, NY 14850

Fax:
Attn: Meghan Dushko
(607) 275-0312

Scan & email to:
meghan@learning-web.org

Please contact Meghan Dushko at (607) 275-0122 or meghan@learning-web.org with any questions or concerns.

Interested in The Learning Web?

Please complete this form and return with signatures to Meghan Dushko 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!*

Student(s):

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.)
☐	☐	Learning Web social media (no name, just photo)

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 ______

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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 __March____________16______2020______
MONTH DAY YEAR

Ending at 12 Midnight on _April______________27______2020___
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.

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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 ____