



**GEORGIA VOLUNTEER HEALTH CARE PROGRAM
VOLUNTEER TEEN PARENTAL CONSENT**

I, _____, grant permission for my child,
Print Parent's Name

_____, to work as a Volunteer for the
Print Minor's Name

Department of Public Health (DPH), Georgia Volunteer Health Care Program. I understand my child will be directly supervised by a DPH Adult Volunteer and will work less than 40 hours per week.

In case of emergency, please contact:

Name: _____ Relationship: _____

Address, City, State & Zip: _____

Home Telephone: _____ Work Telephone: _____

Cell Phone: _____

Name: _____ Relationship: _____

Address, City, State & Zip: _____

Home Telephone: _____ Work Telephone: _____

Cell Phone: _____

Parent waives any and all claims, known or unknown, arising directly or indirectly from any and all volunteer services that the minor provides to the Georgia Volunteer Health Care Program.

Signature of Parent or Guardian

Date