ASSOCIATED STUDENTS AT SACRAMENTO STATE UNIVERSITY
VOLUNTEER AGREEMENT

1. I, _____, agree to work for ASSOCIATED STUDENTS, INC. (ASI) as a volunteer on _____ [name project, activity or special event]

   from _____ (date) to _____ (date) [timeframe of project].

2. I understand that I will earn no wages or benefits and will not be entitled to unemployment insurance benefits upon the termination of this agreement or as a result of this service.

3. I am aware that participation as a volunteer may require periods of standing, lifting and carrying up to 25 pounds and will require the exercise of reasonable care to avoid injury. I am voluntarily participating in this activity with knowledge of the hazards and potential dangers involved, and agree to accept any and all risks of personal injury and property damage.

4. I UNDERSTAND THAT IF I AM INJURED IN THE COURSE OF THE PROJECT, I AM COVERED BY ASI ACCIDENT INSURANCE. I authorize ASI to seek emergency medical treatment on my behalf in case of injury, accident or illness to me arising from my involvement as a volunteer.

5. I understand that the materials and tools provided by ASI are and remain the property of ASI, and I agree to return these tools and any remaining materials to ASI at the end of my volunteer service.

6. I understand that if I am working with Minors I may be subject to a background check and live scan.

7. I grant permission to ASI its employees and agents and California State University, Sacramento and its employees and agents, to take and use visual/audio images of me. I agree that ASI and California State University Sacramento owns the images and all rights related to them. The images may be used in any manner or media without notifying me, such as ASI/University-sponsored websites, publications, promotions, broadcasts, advertisements, posters and theater slides as well as other ASI/University uses. I waive any right to inspect or approve the finished images or any printed or electronic matter than may be used with them, or to be compensated for them.

8. This is the entire agreement between the parties. It replaces and supersedes any and all oral agreements between the parties, as well as any prior writings.

Date _____ Volunteer Signature _____

Printed Name _____ Volunteer Date of Birth

Date _____ Associated Students, Inc., Director or ASI Volunteer Coordinator _____

Printed Name

If volunteer is under 18 years of age, parent or guardian must read and sign the following:
This release, its significance, and assumption of risk have been explained to and are understood by the minor.

Date _____ Parent or Guardian of Volunteer Signature _____

Printed Name

MUST BE COMPLETED FOR ALL VOLUNTEERS UNDER THE AGE OF 18

ASSOCIATED STUDENTS AT SACRAMENTO STATE UNIVERSITY
VOLUNTEER MEDICAL INFORMATION FORM

Name: _____ Daytime Phone: _____

Address: _____ Evening Phone: _____

City: _____ State: _____ Zip: _____

Email: _____

EMERGENCY MEDICAL INFORMATION

Date of Birth: _____ Last tetanus booster date, if available: _____

1. List allergies, if any: (i.e. insect bites, drugs, food, etc. *NOTE*: counteractive medication should be carried at all times.)
   Circle one: NONE YES…
   _____
2. List any medications currently taken:
   Circle one: NONE YES…
   _____
3. List any serious illness or injury occurring in the past three years:
   Circle one: NONE YES…
   _____
4. List any current medical conditions: (i.e. asthma, diabetes, epilepsy, heart conditions, etc.)
   Circle one: NONE YES…
   _____
5. List conditions and instruction, if currently under a doctor's care:
   Circle one: NONE YES…
   _____
6. List any other condition that may affect your ability to participate: (i.e. history of cardiac conditions in family, etc.)
   Circle one: NONE YES…
   _____

Emergency Contact: _____ Daytime Phone: _____

Relationship to Participant: _____ Evening Phone: _____

Doctor: _____ Phone: _____

Insurance: _____ Policy #: _____

AUTHORIZATION TO TREAT A MINOR
MUST BE COMPLETED FOR ALL VOLUNTEERS UNDER THE AGE OF 18

I (we) the undersigned parent, parents or legal guardian of the minor stated above, do hereby authorize and consent for any x-ray examination, anesthetic, medical or surgical diagnosis rendered under the general or special supervision of any member of the medical staff and emergency room staff licensed under the provisions of the Medicine Practice Act or a dentist licensed under the provisions of the Dental Practice Act and on the staff of any acute general hospital holding a current license to operate a hospital from the states of California or Nevada. It is understood that this authorization is given in advance of any specific diagnosis, treatment or hospital care being required but it is given to provide authority and power to render care which the aforementioned physician in the exercise of his best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to the patient, but that nay of the above treatment will not be withheld if the undersigned cannot be reached.

This consent shall remain effective through _____
(Program Date: month /day / year)

_____ _____
PARENT OR GUARDIAN (print name) PARENT OR GUARDIAN SIGNATURE & DATE