

**Ephrata Area School District**  
803 Oak Boulevard, Ephrata, PA 17522  
(717) 721-1513

**VOLUNTEER APPLICATION FORM**

Directions: Complete this form and return it with all listed requirements to the Human Resources Department in the District Office prior to volunteering.

Name: \_\_\_\_\_

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

Phone: Day \_\_\_\_\_ Evening \_\_\_\_\_

Email Address: \_\_\_\_\_@\_\_\_\_\_

Are you a parent or relative of a current EASD student? \_\_\_\_\_

Student's Name: \_\_\_\_\_ School: \_\_\_\_\_ Relationship: \_\_\_\_\_

Student's Name: \_\_\_\_\_ School: \_\_\_\_\_ Relationship: \_\_\_\_\_

Do you currently hold Act 34, 151, and 114 clearances?  
(If you are an EASD employee, please answer "Employee")

If no, have you applied for these clearances: \_\_\_\_\_ Date you applied for clearances: \_\_\_\_\_

**EMERGENCY INFORMATION**

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

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Alternate Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Special Health Problems / Allergies / Medications we should know about: \_\_\_\_\_

Physician Preference: \_\_\_\_\_ Physician Phone: \_\_\_\_\_

Hospital Preference: \_\_\_\_\_ Ambulance Preference: \_\_\_\_\_

In the event that I need emergency treatment requiring ambulance service and/or medical care, you have my permission to seek help as listed above or nearest MD/DO or ambulance/hospital available. I will assume responsibility for fees incurred by such an emergency (via my medical insurance if applicable).

Your signature below indicates that you have received and read the School Volunteers Policy 916 and agree with the terms.

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