Edmund Rice Services – Mt Atkinson
Volunteer Application Form

Name: _____

Address: _____

Phone/Mobile: _____ Email: _____

Date of Birth: _____ Languages spoken: _____

Does the participant identify as Aboriginal or Torres Strait Islander? ☐ Yes ☐ No

Do you: ☐ Work ☐ Study ☐ Stay at Home. Occupation / course studying: _____

Other skills: ☐ Level 2 First Aid ☐ Full Car License ☐ Endorsed License ☐ Food Handling

Gender: ☐ Female ☐ Male ☐ Non-binary ☐ Transgender ☐ Other

Parent / Guardian details (for volunteers under 18 years of age)

Name: _____ Relationship to volunteer: _____

Address: _____

Phone: _____ Mobile: _____

Emergency Contact Details for volunteer (if different to above)

Name: _____ Relationship to volunteer: _____

Phone: _____ Mobile: _____

Next of Kin (if different to above)

Name of Next of Kin:_____ Relationship to volunteer: _____

Phone: _____ Mobile: _____

Medical Information (Please complete details that are known)

Medicare No: _____ Expiry: _____ Health Care Card No: _____ Expiry: _____

Doctor's Name: _____ Dr's Phone: _____

Date of last Tetanus: _____ Ambulance cover: Yes/No (circle)

Private Health Insurance – Provider: _____ Number: _____

Does the volunteer have any of the following dietary requirements?

☐ Vegetarian ☐ Vegan ☐ Gluten Free ☐ Halal
☐ Lactose Intollerance ☐ Dairy Free ☐ Low FodMap ☐ Other

Please describe: _____

Does the volunteer have any allergies?

☐ Nuts ☐ Eggs ☐ Shell Fish ☐ Food additives ☐ Penicillin ☐ Drugs ☐ Other

Please describe: _____

Has the volunteer been diagnosed with Anaphlaxis? ☐ Yes ☐ No

Does the volunteer have an EpiPen? ☐ Yes ☐ No

If the participant has been diagnosed with Anaphylaxis:

❑ Please provide a copy of an **ASCIA action plan** for the volunteer, with an up-to-date photograph. Bring your **Epipen®** (ensure it has not expired)

Has the volunteer been diagnosed with Asthma? ☐ **Mild** ☐ **Intermediate** ☐ **Severe**

If your child's asthma is described as being severe, an asthma management plan signed by a Registered Medical Practitioner must be provided with this application along with dosage amounts and prescribed medications. ☐ Asthma Management Plan Attached

Details: _____

Please tick the appropriate box if the volunteer experiences from the following:

☐ Autism	☐ Epilepsy	☐ Mental Illness	☐ Aspergers Syndrome
☐ ADHD / ADD	☐ Hearing Loss	☐ Physical Disability	☐ Intellectual Disability
☐ Sight Loss	☐ Heart Condition	☐ Diabetes	☐ Other

Details: _____

_____

Do you have any prescribed medication that program staff should know about?

Medication Name	Frequency & Time of day	Dosage	Comments

Do you have a Working With Children Check (WWCC)? ☐ Yes ☐ No (Please tick one option)

If yes, card number**:** _____Expiry date: _____ Please add Edmund Rice Services to your WWCC online file:**https://online.justice.vic.gov.au/wwccu/login.doj?next=mycheck**
If no, you must apply for your WWCC before you can start volunteering.

Referee: Please provide the name and contacts for a referee that is able to support your application.

Name: _____ Phone: _____

Relationship to you: _____

Volunteers over 18 years of age:

I agree that I have read and understood this waiver prior to signing it and agree that this waiver will be binding on my heirs, next of kin, executors and administrators. I agree that this waiver shall be governed in all respects by and interpreted in accordance with the laws of Victoria. I further agree that in the event of any accident or illness and where it is not possible or reasonable to obtain my consent that Edmund Rice Services – Mt Atkinson may on my behalf, engage any medical practitioner or take me to any hospital facilities or other accommodation and in this event I agree to pay any ambulance, doctor, nurse or hospital expenses incurred.

Volunteers under 18 years for whom I am taking legal responsibility:

I_____being the parent/legal guardian of the below named volunteer(s) hereby consent to their participation in the Activities and agree to abide by the Rules annexed to this form. I confirm that I have read and understood and explained this waiver to the participant(s) prior to signing it and agree that this agreement will be binding on my (and their) heirs, next of kin, executors and administrators. I agree that this waiver shall be governed in all respects by and interpreted in accordance with the laws of Victoria I further agree that in the event of any accident or illness and where it is not possible or reasonable to obtain my consent that Edmund Rice Services – Mt Atkinson may on my behalf, engage any medical practitioner or take me to any hospital facilities or other accommodation and in this event I agree to pay any ambulance, doctor, nurse or hospital expenses incurred.

Media Release: I agree that images and videos taken of myself/child while attending an Edmund Rice Services – Mt Atkinson program may be used for publicity purposes. It is understood by both parties that these images/videos are for the sole use of publicity in the form of, brochures, pamphlets, website, social media and on screen images and will under no circumstances be used for any other purpose.

(Please tick one of the following boxes) ☐ Opt in ☐ Opt out

Volunteer Name: _____**Signature:** _____

Date: _____ **Signature(Parent/guardian of volunteer under 18):** _____