**STUDENT VOLUNTEER CONSENT/PARENT CONTRACT**

This is to verify that my son/daughter, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,

has my consent to participate in the Student Volunteer Program at La Rabida Children's Hospital.

I understand that he/she is making a weekly commitment to volunteer at a regularly assigned time for a total of 40 hours.

Students volunteering during the school year are required to give two hours each week for 20 weeks. Students in our summer program must give a total of 40 hours (scheduling to be determined).

To the best of my knowledge, there is no reason why my son’s/daughter’s activities should be limited.

I also understand that a Backtrack criminal background check and DCFS check will be conducted on my son/daughter and that these checks are done on all applicants for paid and unpaid positions at La Rabida Children’s Hospital.

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Signature of Parent or Guardian Date