Sofia Quintero
art and cultural center, inc.

Administrative Offices located at:
The Jose Martinez Memorial Galeria
1222 Broadway St. Second Floor; Toledo, OH 43609

VOLUNTEER INTEREST FORM

Contact name_____

E- Mail _____Phone

_____

Mailing Address _____

City _____ State _____ Zip

_____

VOLUNTEER Please check ALL days and times you are available for:

Days:

_____ Monday _____ Tuesday _____ Wednesday _____ Thursday _____ Friday

_____ Saturday _____ Sunday

Times:

_____ Morning (7:30 am to Noon)

_____ Afternoon (Noon to 5 p.m.)

_____ Evening (5 p.m. to Midnight)

*Please note that we understand that your daily availability may change, the times above are just a guideline.

VOLUNTEER TASKS (Please check ALL tasks you would like to do):

*Please note that additional tasks may be offered

_____ Set-Up or Tear down

_____ Greeters

_____ Alcohol Sales (21+)

_____ Check-In Table

_____ Office Assistance (mailings etc.,)

_____ Gardening

_____ Hospitality

_____ Security

_____ Children's Area

_____ Assist with Classes

_____ Floater

_____ Parking/Traffic Control

_____ Merchandise Sales

_____ Office Cleaning

If you are part of a volunteer group, please list the group. (Each group member must fill-out a volunteer form)

_____

*Volunteering for a special event: _____

Volunteer Signature _____ **Date** _____

TKB 4/2017

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HOLD HARMLESS AGREEMENT

I hereby give my approval to participate in the activity above (registration form attached) at the Sofia Quintero Art and Cultural Center (SQACC). I understand that participation in the activity involves a certain degree of risk. I have carefully considered the risk involved and have given consent for myself to participate in the activity. I understand that participation in the activity is entirely voluntary and requires participants to abide by applicable rules and standards of conduct. I know that participation in said activity may result in serious injuries and protective equipment does not prevent all injuries, and do hereby waive, release, absolve, indemnify and agree to hold harmless the Sofia Quintero Art and Cultural Center Inc., its staff, City of Toledo and all organizations that have a relationship with Sofia Quintero Art and Cultural center Inc. including the organizers, sponsors, participants and persons transporting myself, activity coordinators and all employees, volunteers, related parties or other organizations associated with the activity from any and all claims or liability arising out of participants participation for any claim arising out of any injury to myself whether the result of negligence or for any other cause, except to the extent and in the amount covered by accident or liability insurance.

I case of emergency involving myself, I hereby give my permission to the medical provider selected by the adult leader in charge to secure proper treatment, including hospitalization, anesthesia, surgery or injections of medication for myself. Medical providers are authorized to disclose to the adult in charge examination findings, test results, and treatment provided for purposes of medical evaluation of the participant, follow-up and communication with the participants and participant's parents/guardian, and/or determination of the participant's ability to continue in the program activities.

I agree to return upon request the uniforms and/or other equipment/supplies issued to myself in as good as condition as when I received it except for normal wear and tear. No refund on fees, unless otherwise noted. Program and Activity rules and regulation must be followed. I understand that I may be used in photos, cds, and new releases in publications, websites and marketing mediums at SQACC.

Date: _____

Participants Name: _____

Guardian Name (if applicable): _____

Participant/Guardian Signature: _____

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MEDICAL TREATMENT AUTHORIZATION, EMERGENCY CONTACT AND CONSENT FORM

Full Name: _____

Address: _____

City/State/Zip: _____ Phone: _____

MEDICAL AUTHORIZATION
In case of accident or illness, if unable to contact my emergency contact and the emergency is acute, I hereby authorize SQACC personnel to seek emergency medical care, including transportation to an emergency room for myself. I hereby authorize the Physician/Dentist in charge to administer whatever emergency treatment is necessary at my expense.

Family Physician: _____ Phone: _____

Allergies: _____

Hospital Preference:_____

Family Dentist: _____ Phone: _____

Medical Authorization

I authorize consent for emergency medical treatment of myself	Circle: Yes No
I authorize EMS services to be called and to start treatment on myself	Circle: Yes No
I want the Primary contacts to be notified in the event of an emergency after EMS	Circle: Yes No

I hereby certify that the above information is accurate and valid. If there are any changes to this information, I will immediately notify the SQACC office.

Signature: _____ Date: _____

1. Emergency Contact: _____ Phone: _____

Relationship: _____

2. Emergency Contact: _____ Phone: _____

Relationship: _____