

**Volunteer Parental Consent Form**

Thank you for your interest in volunteering with Women’s College Hospital!

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| **Parental Consent** |
| **Parental or legal guardian consent is required if the if applicant is under the age of 18:**  **Volunteer Applicant Information**  Last Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ First Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  I give consent for my child: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to volunteer at Women’s College Hospital.  Parent/Guardian Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Signature of Applicant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Return to Volunteer Resources, Women’s College Hospital**  **76 Grenville Street, Room 7409**  **(T) 416-323-6400 ext. 6180**  **(E)** [**volunteer@wchospital.ca**](mailto:volunteer@wchospital.ca)  **(F) 416-323-7741** |