

**PARENTAL CONSENT, RELEASE, AND WAIVER OF LIABILITY FOR MINOR VOLUNTEERS**

It is the policy of Crossroads Hospice that children under the age of 16 are not allowed to participate as a volunteer. It is further the policy of Crossroads Hospice that, while children between the ages of 16 and 18 may be allowed to participate as a volunteer for Crossroads Hospice.

This Parental Consent, Release, and Waiver of Liability executed on:

this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

by: \_\_\_\_\_, a minor child (the "Volunteer"),

and \_\_\_\_\_, the parent having legal custody and/or the legal guardian of the volunteer (the "Guardian"), in favor of Crossroads Hospice, their directors, governing body, officers, employees, physicians, ancillary personnel and agents (collectively, "Crossroads").

The Volunteer and Guardian desire that the Volunteer work as a volunteer for Crossroads and engage in the activities related to being a volunteer. The Volunteer and the Guardian understand that the activities may include, but not limited to, visiting patients and family members whom reside in long term care facilities, assisted living facilities, hospitals and/or other healthcare facilities, as well as personal homes. Also, due to the nature of hospice, death of a patient may occur while the minor is present.

The Volunteer and Guardian do hereby freely, voluntarily, and without duress execute this Release under the following terms:

1. **Release and Waiver.** Volunteer and Guardian do hereby release and forever discharge and hold harmless Crossroads Hospice and its successors and assigns from any and all liability, claims, and demands of whatever kind or nature, either in law or in equity, which arise or may hereafter arise from Volunteer's activities with Crossroads Hospice. Volunteer and Guardian understand that this Release discharges Crossroads Hospice from any liability or claim that the Volunteer or Guardian may have against Crossroads Hospice with respect to any bodily injury, personal injury, illness, death, or property damage that may result from Volunteer's activities with Crossroads Hospice, whether caused by the negligence of Crossroads Hospice or its officers, directors, employees, other volunteers or otherwise arising. Volunteer and Guardian also understand that Crossroads Hospice does not assume any responsibility for or obligation to provide financial assistance or other assistance, including but not limited to medical, health, or disability insurance in the event of injury or illness.
2. **Medical Treatment.** Volunteer and Guardian do hereby release and forever discharge Crossroads Hospice from any claim whatsoever which arises or may hereafter arise on account of any first aid, treatment, or service rendered in connection with the Volunteer's activities with Crossroads Hospice or with the decision by any representative or agent of Crossroads Hospice to exercise the power to consent to medical or dental treatment. Permission is granted to Crossroads Hospice's adult volunteers or employees to obtain medical care from any licensed physician, hospital, or medical clinic for the above named at such times deemed necessary for physical health purposes. This authorization shall include all Crossroads Hospice activities including travel required to obtain medical care. Volunteer and Guardian hereby waive all claims against and agree not to sue Crossroads Hospice, its officers, agents, employees and volunteers as a result of Volunteer participation in this volunteer activity or any claim arising from injury of Volunteer in the execution of the above actions.



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#### Parental Consent and Waiver –Minor Volunteer

3. **Assumption of the Risk.** The Volunteer and Guardian understand that the activities may include activities that may be hazardous to the Volunteer, including, but not limited to, inadvertently or directly coming in contact with biohazardous agents, communicable diseases, and environmental issues such as patient's residing in homes that are located in high traffic areas, high crime areas, pets, rodent/insect infestation, patients / family members who smoke and/or combative patients. Volunteer and Guardian hereby expressly and specifically assume the risk of injury or harm in the activities and release Crossroads Hospice from all liability for injury, illness, death, or property damage resulting from any and all activities.
4. **Photographic Release.** Volunteer and Guardian do hereby grant and convey unto Crossroads Hospice all right, title, and interest in any and all photographic images and video or audio recordings made by Crossroads Hospice during the Volunteer's activities with Crossroads Hospice, including, but not limited to, any royalties, proceeds, or other benefits derived from such photographs or recordings.
5. **Other.** Volunteer and Guardian expressly agree that this Release is intended to be as broad and inclusive as permitted by the laws of the State and that this Release shall be governed by and interpreted in accordance with the laws of the State. Volunteer and Guardian agree that in the event that any clause or provision of this Release shall be held to be invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not otherwise affect the remaining provisions of this Release which shall continue to be enforceable.

I hereby consent to allow the above minor to participate as a volunteer for Crossroads Hospice. I also attest that the age/date of birth of the minor volunteer is correct.

\_\_\_\_\_  
Volunteer Name (print)

\_\_\_\_\_  
Volunteer's D.O.B. (Must be at least 16 years of age)

\_\_\_\_\_  
Parent/Guardian Name (Print)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Parent/Guardian Cell Phone

\_\_\_\_\_  
Volunteer Cell Phone (if applicable)

Expect more from us. We do.



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## RELEASE FORM FOR MINOR VOLUNTEER FOR REQUIRED PHYSICAL HEALTH EXAM

Minor Volunteer Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

I fully and totally consent to allow my child listed above, to receive a physical health exam by a qualified healthcare professional. This exam is required per state and federal law for all employees and direct care hospice volunteers. I acknowledge that TB testing is generally safe; however, I hereby release Crossroads Hospice, its employees, owners, board of directors and affiliates from any and all liability from my choice to allow my child to receive the above exam. I understand that any /all individuals performing the exam have been properly and thoroughly trained and licensed by the state as a registered nurse or a physician.

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness's Signature

\_\_\_\_\_  
Date



Expect more from us. We do.

## RELEASE FORM FOR MINOR VOLUNTEER TO OBTAIN REQUIRED TB TESTING

Minor Volunteer Name: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

I fully and totally consent to allow my child listed above, to obtain TB testing, which is required per state and federal law for all direct care hospice volunteers. I acknowledge that TB testing is generally safe; however, I hereby release Crossroads Hospice, its employees, owners, board of directors and affiliates from any and all liability from my choice to allow my child to obtain TB skin testing. I understand that individual performing the TB testing/skin injection have been properly and thoroughly trained and is licensed as a nurse.

\_\_\_\_\_  
Parent/Legal Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness's Signature

\_\_\_\_\_  
Date