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|--------------------------------|-------------------|
| Do you have a passport? | Country of origin |
| Name as it appears on passport | |
| Expiration date | Passport # |

List hobbies, talents, special skills, etc. that you feel might be helpful on this pilgrimage:

Are you certified in CPR, epipens or any other medical training? If so, please list:

| BECAUSE YOU ARE APPLYING TO VOLUNTEER WITH CHILDREN AND VULNERABLE ADULTS, PLEASE ANSWER THE FOLLOWING: | YES or NO |
|--|-----------|
| Have you ever been convicted of a criminal offense (except traffic violations)? | |
| Has an order ever been made against you to remove a child from your care or your home? | |
| Has an order ever been made against you regarding a child in your care found to need protection, care or control? | |
| Are you in good mental/emotional health? | |
| Do you abuse alcohol, illegal drugs or prescription drugs? | |
| In the past 5 years, have you had a medical, emotional or psychological condition that could affect your ability or suitability to act as a volunteer and care for special needs young people? | |
| Have you taken <i>Protecting God's Children</i> ? If YES, year of last certification _____ | |
| Have you had a background check performed in the past 2 years? If YES, check here <input type="checkbox"/> if it was done by ASCPG. If NO, we will run one. | |

Anything else we should know?

Volunteer Consent and Waiver – ASCPG Easter Pilgrimage to Lourdes

Please read carefully, and initial each section to convey your understanding and agreement.

___ I understand that the American Special Children’s Pilgrimage Group (ASCPG) must have a complete picture of an applicant to make an informed decision about acceptance for the trip. Therefore, I testify that all information on every page of this application is true, and I have added additional information that pertains to my health and background.

___ If I am accepted for the trip, I will provide updated information on my medical, mental, emotional and legal condition, between today and the date of the ASCPG Easter trip to Lourdes.

___ I am suitable in every way to perform the work and duties of an ASCPG volunteer in Lourdes.

___ I will participate in fundraisers, events, meetings and the trip orientation, at the direction of my Group Leader.

___ I will abide by all ASCPG Child Protection Policies. I will not be under the influence of alcohol when I am caring for, or in the presence of, the special needs pilgrims. I will not use or bring illegal drugs, or be under the influence of illegal drugs, during the pilgrimage and all ASCPG activities.

___ By signing this consent, I waive ASCPG of any and all liability regarding any and all illness, accident or fatality arising from my trip to Lourdes.

___ If I am accepted for the Lourdes pilgrimage, I give permission for my photo and image to be used for publicity purposes, including ASCPG brochures, the ASCPG website and ASCPG-run social media accounts.

___ I understand that if I require medical attention above and beyond what ASCPG can provide (i.e., requires a visit to the hospital emergency room or hospital admission) in Lourdes, I will be treated under the auspices of the French medical system. This means ASCPG will have no authority in the diagnosis or treatment process.

By signing below, I/we acknowledge that I fully comprehend the above:

| | |
|------------------------|-------|
| Print Applicant’s Name | Date: |
| Applicant’s signature | |

| ALL doctors who regularly treat you | Address & Phone | Type of Doctor |
|-------------------------------------|-----------------|----------------|
| | | Primary Care |
| | | |
| | | |

| Current prescription & OTC medications | Dosage | Reason prescribed |
|--|--------|-------------------|
| | | |
| | | |
| | | |

| PERSONAL HEALTH QUESTIONNAIRE | YES – please explain | NO |
|--|----------------------|----|
| Do you have heart problems? | | |
| Do you have diabetes? | | |
| Do you have kidney problems? | | |
| Are you prone to fainting? | | |
| Do you have back problems? | | |
| Do you have knee problems? | | |
| Do you have allergies (food, drug, environmental)? | | |
| Is activity restricted due to disability/medical reason? | | |
| Do you have special dietary needs? | | |
| Is there anything else you would like to share? | | |

| | |
|---|----------------------------|
| <p>Physician Statement and Signature: I understand that my patient is applying to volunteer with special needs youth for one week in France. To the best of my knowledge, the information he/she provided here is true.</p> <p>Physician Signature _____</p> <p>Print Name _____ phone _____</p> | <p>Date:</p> <p>Stamp:</p> |
|---|----------------------------|

