Permission for Release of School Information

Date:__________________________

I,____and my parent/guardian
(Print Student's Name)

____give permission for the release of any
(Print Parent/guardian's Name)

information and/or records requested by **Wellstar North Fulton Medical Center Volunteer Serivces.**

Name of School:____

Address of School:____

____

School Counselor's Name:____

School Counselor's e-mail:____

Signature of Student:____

Signature of Parent/Guardian:____

STUDENT – DO NOT WRITE BELOW THIS LINE AND RETURN WITH APPLICATION

High School Counselor – please print. The student listed above has applied for the Wellstar North Fulton Hospital VolunTeen program. Please complete the below information and return this form as soon as possible, as your recommendation is one requirement for consideration of acceptance.

1. Student's GPA:________________
2. Is the applicant responsible? ☐ Yes ☐ No

Comments: ____

3. To your knowledge, does the applicant have any physical or emotional concerns that would affect their ability to work with patients? ☐ Yes ☐ No **If yes, please explain.**

____

4. Any additional comments: ____

____

____

Counselor's Signature   Date

Please email to: NFHVolunteers@Wellstar.org
FAX: (470) 986-7080

Department of Volunteer Services * 3000 Hospital Boulevard * Roswell, GA 30076
*NFHVolunteers@Wellstar.org