DAY VOLUNTEER INFORMATION

GENERAL INFORMATION

Location of BREAKAWAY: Lake Yale Conference Center	Legal Name (Last, First, Middle):	Preferred Name:
Street Address:		City, State & Zip:
Primary/Home Phone:	Work Phone:	Cell Phone:
Email Address:		Social Security #:
Date of Birth:	Gender: ☐ Male ☐ Female	Married: ☐ Yes ☐ No
In case of emergency please contact: (first and last name)		Relationship:
Address:	City, State & Zip:	Daytime Phone: / Cell Phone:

What areas are you interested in serving in:

Archery: ☐	Canoeing: ☐	Spa: ☐
Boating: ☐	Buddy to Family: ☐	Serving Food: ☐
Fishing: ☐	Games/ Recreation: ☐	All/ Greatest Need: ☐
Arts and Crafts: ☐	Pool: ☐	Other:

Please list previous volunteer experience: What type of volunteering, With whom did you volunteer, your volunteer responsibilities in the past?

Would you like your contact information shared with other attendees by appearing on a mailing list?: ☐ Yes ☐ No

MEDICAL HISTORY

Height: / Weight:	Medical History:
List any allergies: List any food allergies or restrictions: List any medications you are currently taking:	
Insurance Policy Carrier:	Insurance Policy Number:
Doctor's Name:	Doctor's Phone:

PLEASE READ CAREFULLY, INITIAL AFTER EACH ITEM AND SIGN THAT YOU UNDERSTAND AND ACCEPT THIS INFORMATION.

— I give my consent that information on this page may be communicated to BREAKAWAY staff and Crew Members for the purpose of being equipped to provide the best care and assistance possible to everyone at BREAKAWAY. I have given my Social Security # for the release of my criminal records to determine acceptance and have signed the attached Background Authorization Form.

— Permission is given only to Lift Disability Network to use photographs (individual or group) and/or multi-media images and recordings in the best interest of Lift Disability Network. I understand that photographs/video/images I take at any BREAKAWAY/Lift Disability Network function are for my personal use only. Personal internet use of any video/media should be approached with caution with regard to misrepresentation.

— I release Lift Disability Network, its staff, and Crew Members, and the BREAKAWAY facility from all actions, damages, or personal injuries which may occur to me. I understand in the event of a minor injury I may receive first aid treatment. In the event of an emergency, injury, or illness, emergency medical services and I will decide the best course of action.

— I understand that all staff, including myself and all participants, have limited insurance coverage against injury or illness only. Therefore, if my misconduct results in a lawsuit, I understand I will represent myself. I shall indemnify Lift Disability Network and its staff, and hold them harmless from and against liability or responsibility for my negligence or misconduct.

— I understand that participation includes possible exposure to and illness from infectious diseases including but not limited to MRSA, influenza, and COVID-19. While particular rules and personal discipline may reduce this risk, the risk of serious illness and death does exist; and,

— I KNOWINGLY AND FREELY ASSUME ALL SUCH RISKS, both known and unknown, EVEN IF ARISING FROM THE NEGLIGENCE OF THE RELEASEES or others, and assume full responsibility for my participation; and,

— I willingly agree to comply with the stated and customary terms and conditions for participation as regards protection against infectious diseases. If, however, I observe and any unusual or significant hazard during my presence or participation, I will remove myself from participation and bring such to the attention of the nearest official immediately.

— I realize that tobacco, alcohol, and illegal drugs are NOT ALLOWED.

Signature: _____ Date: _____

Lift Disability Network
PO Box 770607
Winter Garden, FL 34777
407.228.8343
www.liftdisability.net/breakaway

If you wish to join us for meals the cost will be: Breakfast $9, Lunch $13 and Dinner $16. Anyone wishing to serve multiple days will need to pay an additional $15 day rate.

DISCLOSURE AND AUTHORIZATION FORM
TO OBTAIN BACKGROUND REPORTS FOR VOLUNTEER PURPOSES

Please Read Carefully Before Signing the Authorization

DISCLOSURE

In considering you as a volunteer, ***Lift Disability Network*** will order a background report about you that we obtain from a consumer reporting agency, Protect My Ministry, Inc.

The background report may contain information concerning your character, general reputation, personal characteristics, and mode of living. The types of information that may be ordered include but are not limited to: Social Security number verification; criminal, public, educational and, as appropriate, driving records checks; verification of prior employment; reference, licensing and certification checks; and drug testing results. The information may be obtained from private and public record sources, including personal interviews with your associates, friends, and neighbors. (An "investigative consumer report" is a background report that includes information from such personal interviews, except in California where that term means any background report.)

Under the FCRA, before the Company can obtain a background report about you for employment or volunteer purposes, we must have your written authorization. Before we take adverse action on the basis, in whole or in part, of information in that report, you will be provided a copy of that report, the name, address, and telephone number of the consumer reporting agency, and a summary of your rights under the FCRA.

AUTHORIZATION

I have read and understand the foregoing Disclosure, and authorize **LIFT DISABILITY NETWORK** to obtain and rely upon background reports in considering me as a volunteer. By my signature below, I authorize Lift Disability Network to obtain any such reports and to share the information received with any person involved in the volunteer decision about me.

I also agree that this Disclosure and Authorization in original, faxed, photocopied, or electronic (including electronically signed) form will be valid for any consumer reports that may be requested about me by or on behalf of Lift Disability Network.

_____
Printed Name

_____ _____
Applicant Signature Date

_____ _____
Parent or Legal Guardian Signature Date
(for searches conducted on minors under the age of 18)