Fun City Youth Academy
Volunteer Application

Personal Information:

Name: _____

Address: _____

_____

Date of Birth ____/____/____ Home Phone: (____)_____ Cell Phone: (____)_____

E-Mail Address: _____

Emergency Contact: _____ Phone: (____)_____

Volunteer Type (Check One):

☐ Service Learning

College/University: _____ Course: _____

Number of Hours Required: _____ Date to be Completed: ____/____/_____

Degree/Major: _____

☐ Club/Organization

Name of Club/Organization: _____

☐ Employer

Name of Employer: _____

☐ Parent

☐ Community Volunteer

Number of Hours Required: _____ Date to be Completed: ____/____/_____

Availability:

Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

How did you hear about volunteer opportunities with Fun City Youth Academy? _____

_____

_____

Have you ever been convicted of a criminal offense? Please explain.

_____

_____

_____

Tell us about any preferences you have (i.e. Age Groups, Small Group or One-on-One, etc.): _____

_____

_____

How can Fun City Youth Academy help you meet your community service goals?

_____

_____

Summarize any special skills or qualifications you have acquired from education, employment, previous volunteer work, or through other activities including hobbies or sports.

Summarize your previous volunteer experience.

Summarize your experience working with children.

Summarize your hobbies.

What training, resources, or support do you anticipate needing to carry out your volunteer commitment? Please include any physical accommodations to successfully volunteer here.

Acknowledgements

I affirm that the information provided in this application is true and complete to the best of my knowledge, and agree to have any of the information checked by the organization or its representatives. I understand that providing false or misleading information or omitting relevant information could result in my termination from the volunteer program. I authorize representatives of Fun City Youth Academy to conduct background screenings, speak to references, and obtain information about me from sources required by my assigned site.

I understand that I am applying to be an unpaid volunteer of Fun City Youth Academy, and this is not an application for employment. I understand that nothing in this application is intended to imply or create an employment relationship or a contract for potential employment. If I am accepted as a volunteer, I will abide by all policies, procedures, and other requirements.

_____ _____

Signature Printed Name

_____

Date

Fun City Volunteer Agreement

I, _____, agree to the contractual terms of Fun City Youth Academy as a volunteer.

I accept my role as a MU Service Learning volunteer and understand that I am expected to be present on Saturdays from 11:00 am to 4:15 pm, starting on _____ and ending on _____ or ___ number of sessions.

Part 1: Fun City Youth Academy

Fun City Youth Academy commits itself to:

1. **Introduction and training**
   - Provide you with an introduction to the work of the Fun City Saturday Academy and its staff, your volunteering role and the training you need to meet the responsibilities of this role. The Volunteer Handbook provides details of the organization.

2. **Supervision, support and flexibility**
   - Explain the standards we expect for our services and to encourage and support you to achieve and maintain them.
   - Provide a staff member who will meet with you to discuss your volunteering and any successes and problems at your request.
   - Do our best to help you develop your volunteering role with us.

3. **Safe Work Policy**
   - Provide adequate training and feedback in support of our safety policies, as stated in the Volunteer Handbook

4. **Insurance**
   - Supply adequate insurance coverage for volunteers when undertaking voluntary work approved and authorized by us.

5. **Equal opportunities**
   - Ensure that all volunteers are dealt with in accordance with our equal opportunities policy, a copy of which is set out in the Volunteer Handbook.

6. **Problems**
   - Attempt to resolve any problems, grievances or difficulties you may have while you volunteer with us.
   - Offer an opportunity to discuss issues, in the event of an unresolved problem, in accordance with the procedures set out in the Volunteer Handbook.

Part 2: The volunteer

I, (volunteer's name)_____ agree:

- To help Fun City Youth Academy fulfil its Saturday Youth Academy mission
- To perform my volunteering role to the best of my ability
- To follow the organization's procedures and standards, including those relating to the Safe Work and Equal Opportunities, in relation to its staff, volunteers and students.

- To arrive on time and be physically and mentally present during the Fun City hours of operation
- To give at least two days notice in the event of my absence so that other arrangements can be made
- To agree to a police and background check as it is a standard procedure
- **That all information I may gain about programs or persons served by Fun City Youth Academy will be held in strict confidence and I understand that failure to maintain confidentiality will be grounds for my immediate termination.**
- That this agreement is binding in honour only, is not intended to be a legally binding contract between us and may be cancelled at any time at the discretion of either party. Neither of us intends any employment relationship to be created either now or at any time in the future.

Part 3: Photo Release

Fun City Youth Academy utilizes the service of photographers on site and at events. I am willing to have my photograph taken and publicized on promotional material during my service as a volunteer.

Signed by volunteer: _____
Name (print): _____ Date: _____

Signed on behalf of Fun City Youth Academy:
Signature: _____ Position: _____
Name (print): _____ Date: _____

We wish to assure you of our appreciation of your volunteering with us and will do the best we can to make your experience of volunteering with us enjoyable and rewarding.

Missouri Department of Health and Senior Services
Family Care Safety Registry

RESET

WORKER REGISTRATION

FCSR USE ONLY

Register online at www.health.mo.gov/safety/fcsr OR mail this form, copy of Social Security card, and payment to **Missouri Dept. of Health and Senior Services, Fee Receipts, PO Box 570, Jefferson City, MO 65102.**

REGISTRATION TYPE (Check all that apply. Complete column on right only if Long Term Care/Personal Care selected from left.)

- ☐ Adoptive Parent (Agency Name: _____)
- ☐ Child Care
- ☐ Foster Parent/Family Member of Foster Parent (County Office: _____)
- ☐ Hospital
- ☐ Long Term Care/Personal Care (*Please choose subcategory at right →.*)
- ☐ Mental Health/Psychiatric Hospital
- ☒ Voluntary (*Select voluntary if no other registration type applies.*)

A one-time registration fee of **$12.00** applies to all categories except Foster Parents. Foster Parents must list the Children's Division county office.

Register only once. If you believe you have already registered, check our website at www.health.mo.gov/safety/fcsr or call, toll free, 866-422-6872.

Long Term Care / Personal Care Subcategories (Complete if LTC/PC selected at left.)

- ☐ Adult Day Care
- ☐ Assisted Living Facility
- ☐ Hospice
- ☐ Hospital LTAC/Swing Bed
- ☐ Mental Health – Residential Facility/ICF
- ☐ Nursing Facility/Skilled Nursing
- ☐ Personal Care – Home Health
- ☐ Personal Care – In-Home Services
- ☐ Personal Care – Consumer Directed Services/Center for Independent Living
- ☐ Personal Care – HCY/PDW/DDD/Other

SOCIAL SECURITY NUMBER (Mail copy of card with form.)

— —

PERSONAL INFORMATION (Provide all names you have used, starting with most recent. Include legal names and nicknames.)

LAST NAME	FIRST NAME	MIDDLE NAME	SUFFIX (Jr., Sr., II, III)

MAIDEN NAME (If applicable)	PRIOR NAMES USED (If applicable, list first and last names.)	DATE OF BIRTH (mm-dd-yyyy)	GENDER
		- -	☐ M ☐ F

CONTACT INFORMATION

MAILING ADDRESS (Enter your street address or post office box. This address must be different from Employer Address.)

CITY	STATE	ZIP CODE	COUNTY

TELEPHONE	EMAIL ADDRESS (Required)	COUNTRY (Complete *only* if U.S. territory/outside U.S.)
( ) -		

EMPLOYER ASSOCIATED WITH THIS REGISTRATION (Complete either left or right column, not both.)

☐ My current/potential child care, long term care or mental health care employer is:

EMPLOYER NAME

EMPLOYER ADDRESS

EMPLOYER CITY	STATE	ZIP

EMPLOYER TELEPHONE	EMPLOYER CONTACT NAME	EMPLOYER CONTACT TITLE
( ) -		

☒ No Employer, because I am a(n):

- ☐ Adoptive Parent
- ☐ Foster Parent/Family Member
- ☐ Home Child Care Provider
- ☐ Private Pay/Private Duty
- ☐ Student
- ☒ Volunteer
- ☐ Other (Explain: _____)

REGISTRATION AGREEMENT

The information provided is complete and accurate to the best of my knowledge. I understand it is unlawful to withhold or falsify information required on this form. I grant my permission for the Missouri Department of Health and Senior Services (DHSS) to obtain any and all background information authorized by law to process this request. Furthermore, I authorize the DHSS to release the fact that I am a registrant in the Family Care Safety Registry (FCSR) and any related background information to the requester of the FCSR for employment purposes only, as provided in §210.921, subsection 1, subdivisions (1) and (2), RSMo. For purposes of the FCSR, "employment purposes" includes direct employer/employee relationships, prospective employer/employee relationships, and screening and interviewing of persons or facilities by those persons contemplating the placement of an individual in a child care, elder care or personal care setting. I understand that if I dispute the information contained in the FCSR I have the right to appeal the accuracy of the transfer of information to the FCSR within thirty (30) days of receiving the results of the background screening.

NOTICE: The FCSR may choose to deposit the check enclosed electronically as an ACH debit entry to my designated bank account. I understand that my signature below authorizes my financial institution to deduct this payment from my account. In the event that DHSS or its subcontractor is unable to secure funds from my account or I provide insufficient or inaccurate information regarding my account, my obligation to the DHSS will remain unpaid and further collection action may be taken by the DHSS or its subcontractor, including, but not limited to, returned check fees.

SIGNATURE OF APPLICANT (Must be signed in blue or black ink.)	DATE OF SIGNATURE (Must be within six months of submission.)
➤	- -

WHAT IS THE FAMILY CARE SAFETY REGISTRY?

The Family Care Safety Registry (FCSR), administered by the Missouri Department of Health and Senior Services (DHSS), provides families and employers with a method to obtain background screening information. The Registry, through various state agencies, offers several resources to screen child care, long term care and mental health workers:

- State criminal history and sex offender registry records maintained by the Missouri State Highway Patrol
- Child abuse/neglect records maintained by the Missouri Department of Social Services
- The Employee Disqualification List maintained by the Missouri Department of Health and Senior Services
- The Employee Disqualification Registry maintained by the Missouri Department of Mental Health
- Child care facility licensing records maintained by the Missouri Department of Health and Senior Services
- Foster parent records maintained by the Missouri Department of Social Services

WHO HAS TO REGISTER?

Any person hired on or after January 1, 2001, as a child care worker or elder care worker, hired on or after January 1, 2002, as a personal care worker, or hired on or after January 1, 2009, as a mental health worker, as provided in §210.906, RSMo, is required to make application for registration in the Family Care Safety Registry within fifteen (15) days of the beginning of employment. **Such person who fails to submit a completed registration form to the DHSS without good cause, as determined by the department, is guilty of a class B misdemeanor.** Employees and volunteers from non-state and/or federally regulated entities are NOT REQUIRED to register with the FCSR.

HOW DO I COMPLETE THE REGISTRATION FORM?

Registration Type – Check at least one box from the left column for type of registration that best describes your worker category. If no other type applies, select "Voluntary." (A "voluntary registrant" is a person who is not mandated to register with the Family Care Safety Registry pursuant to §210.900 *et seq.*, RSMo.) If you checked Long Term Care / Personal Care, please *also* make one or more selections from the column on the right for subcategory.

Social Security Number – You must provide your Social Security number pursuant to 19CSR 30-80.030(1). This identifying information, including Social Security number, will be used for internal identification purposes and to conduct background screenings for the resource information listed in paragraph one above.

Personal Information – List your current Last Name, First Name, Middle Name, and any suffix associated with your last name. List any other names by which you may have been known, including maiden names, past married names, and nicknames (attach additional sheets if needed). For identification purposes, list your gender and date of birth.

Contact Information – List your address, city, state, ZIP code, and county. Include your telephone number and email address. We will use this information to notify you of registration results and any background screenings conducted. Email notifications will be encrypted for improved security. To reduce postage costs, the Family Care Safety Registry may contact you to request a personal email address if one is not provided.

Employer Associated with this Registration - If you are currently employed by or are seeking employment with a child care or long term care provider, please list the facility name, address, telephone number, and contact person. If registration is not for employment purposes, make a selection from column on right.

Registration Agreement – Sign and date the registration form. Your signature will authorize the Family Care Safety Registry to conduct the background screening outlined in §210.903.2, RSMo and to provide the information to requesters for employment purposes, as provided in §210.921.1, RSMo.

WHERE DO I SEND MY REGISTRATION FORM?

Send your completed registration form and photocopy of Social Security card and required fee to the **Missouri Department of Health and Senior Services, ATTN: Fee Receipts, P.O. Box 570, Jefferson City, MO 65102**. If you have questions, please call the Registry using the toll-free telephone number, **866-422-6872**.

WHEN WILL I KNOW THE RESULTS OF MY BACKGROUND SCREENING?

After the background screening has been completed, you will be notified in writing of the results that will be recorded in the Family Care Safety Registry. You will also be notified in writing each time background screening information is provided. The notification will contain the name and address of the person who made the request and the background information disclosed. The person making the request will be informed that information will be released for employment purposes only, pursuant to §210.921.1, RSMo. Any person using Registry information for any other purpose is guilty of a class B misdemeanor. In addition, state agencies can request information for licensure or regulatory purposes. Prior to disclosing information, the Registry obtains the name and address of the requester, and determines that the request is for employment or regulatory purposes. To ensure you receive these notifications, it will be important for you to notify the Family Care Safety Registry when you have a change in your contact information. *Notify the Family Care Safety Registry of changes in personal or contact information using the toll-free telephone number, 866-422-6872, by email to fcsr@health.mo.gov, or by mail to FCSR, PO Box 570, Jefferson City, MO 65102.*

WHAT IF I DON'T AGREE WITH THE RESULTS OF MY BACKGROUND SCREENING?

As provided in §210.912, RSMo, you have the right to appeal the information transferred to the Family Care Safety Registry. Your right to appeal is limited to the accuracy of the *transfer* of information from the state agency that maintains the background information and does not include a right to appeal the accuracy of the *substance* of the information transferred. An appeal must be filed in writing to the Office of the Director, Missouri Department of Health and Senior Services, P.O. Box 570, Jefferson City, MO, 65102, within 30 days of receiving the results of the background screening determination. An administrative appeal shall be set within 30 days of the filing of the appeal and a decision shall be made within 60 days. This right to appeal is in addition to any other appeal rights granted by state law.

WHAT INFORMATION WILL BE DISCLOSED BY THE FAMILY CARE SAFETY REGISTRY?

Disclosure of background information on a person registered in the Family Care Safety Registry will be limited. If the person is registered, the Registry worker will disclose whether the person's name is listed in any of the background checks pursuant to §210.903, subsection 2, RSMo, and if so, which one(s). Specific information will be disclosed by the Registry pursuant to §210.921, subsection 1, subdivision (2).

Missouri Department of Health and Senior Services
Bureau of Communicable Disease Control and Prevention

Tuberculosis (TB) Risk Assessment Form

Patient's Name: _____ **Date of Birth:** _____ **Date:** _____
Address: _____ **Phone Number:** _____

A. Please answer the following questions (Sections A & B to be completed by Patient):	
Have you ever had a positive Mantoux tuberculin skin test (TST)?	☐ Yes ☐ No
Have you ever been vaccinated with BCG?	☐ Yes ☐ No
Have you ever had a positive Interferon Gamma Release Assay (IGRA) test?	☐ Yes ☐ No
Have you ever been diagnosed with or treated for TB Disease?	☐ Yes ☐ No
B. TB Risk Assessment	
Have you ever had close contact with anyone who was sick with tuberculosis?	☐ Yes ☐ No
Have you ever traveled to one or more of the countries listed below? **If yes, please CHECK the countries.**	☐ Yes ☐ No
Were you born in one of the countries listed below? **If yes, please list the country:** _____ What year did you arrive in the United States? _____	☐ Yes ☐ No

Afghanistan	Cape Verde	Gabon	Kuwait	Myanmar	St. Vincent &	Tokelau
Algeria	Central African Rep.	Gambia	Kyrgyzstan	Namibia	The Grenadines	Tonga
Angola	Chad	Georgia	Lao PDR	Nauru	Sao Tome & Principe	Trinidad & Tobago
Anguilla	Chile	Ghana	Latvia	Nepal	Saudi Arabia	Tunisia
Argentina	China	Greenland	Lesotho	Nicaragua	Senegal	Turkey
Armenia	Colombia	Guatemala	Liberia	Niger	Serbia	Turkmenistan
Azerbaijan	Comoros	Guinea	Libyan Arab Jamihirya	Nigeria	Seychelles Sierra	Turks & Caicos
Bahrain	Congo	Guinea-Bissau	Lithuania	Niue	Leone	Islands
Bangladesh	Congo DR	Guam	Macedonia-TFYR	Northern Mariana	Singapore	Tuvalu
Belarus	Cote d'Ivoire	Guyana	Madagascar	Islands	Solomon Islands	Uganda
Belize	Croatia	Haiti	Malawi	Pakistan	Somalia	Ukraine
Benin	Djibouti	Honduras	Malaysia	Palau	South Africa	Uruguay
Bhutan	Dominica	Hungary	Maldives	Panama	Sri Lanka	Uzbekistan
Bolivia	Dominican Republic	India	Mali	Papua New Guinea	Sudan	Vanuatu
Bosnia & Herzegovina	Ecuador	Indonesia	Marshall Islands	Paraguay	Sudan - South	Venezuela
Botswana	Egypt	Iran	Mauritania	Peru	Suriname	Viet Nam
Brazil	El Salvador	Iraq	Mauritius	Philippines	Syrian Arab Republic	Wallis & Futuna
Brunei Darussalam	Equatorial Guinea	Japan	Mexico	Poland	Swaziland	Islands
Bulgaria	Eritrea	Kazakhstan	Micronesia	Portugal	Tajikistan	Yemen
Burkina Faso	Estonia	Kenya	Moldova-Rep.	Qatar	Tanzania-UR	Zambia
Burundi	Ethiopia	Kiribati	Mongolia	Romania	Thailand	Zimbabwe
Cambodia	Fiji	Korea-DPR	Morocco	Russian Federation	Timor-Leste	
Cameroon	French Polynesia	Korea-Republic	Mozambique	Rwanda	Togo	

Source: World Health Organization Global Tuberculosis Control, WHO Report 2013, Countries with Tuberculosis incidence rates of > 20 cases per 100,000 population. For future updates, refer to http://www.who.int/topics/tuberculosis/en/.

Have you ever had an abnormal chest x-ray suggestive of TB?	☐ Yes ☐ No ☐ No Response
Are you HIV positive?	☐ Yes ☐ No ☐ No Response
Are you an organ transplant recipient or donor?	☐ Yes ☐ No ☐ No Response
Are you immunosuppressed (taking an equivalent of > 15 mg/day of prednisone for ≥1 month, or currently taking prescription arthritis medication)?	☐ Yes ☐ No ☐ No Response
Are you a resident, employee, or volunteer in a high-risk congregate setting (e.g., correctional facilities, nursing homes, homeless shelters, hospitals, and other health care facilities)?	☐ Yes ☐ No ☐ No Response
Do you have any medical conditions such as diabetes, silicosis, head, neck, or lung cancer, hematologic or reticuloendothelial disease such as Hodgkin's disease or leukemia, end stage renal disease, intestinal bypass or gastrectomy, chronic malabsorption syndrome, low body weight (i.e., 10% or more below ideal)?	☐ Yes ☐ No ☐ No Response
Do you have a cough lasting 3 weeks or longer, chest pain, weakness or fatigue, weight loss, chills, fever and/or night sweats?	☐ Yes ☐ No ☐ No Response
Are you coughing up blood or phlegm?	☐ Yes ☐ No ☐ No Response

I hereby certify that this application contains no misrepresentation or falsification and that the information given by me is true and complete to the best of my knowledge and belief.

_____ Patient Signature (Required)

_____ Date:

Missouri Department of Health and Senior Services
Bureau of Communicable Disease Control and Prevention

Tuberculosis (TB) Risk Assessment Form

C. Medical Evaluation (Section C to be completed by Health Care Provider – if needed)

Health Care Provider: If the answer to any of the TB Risk Assessment questions in Section B is YES or NO RESPONSE, proceed with additional medical evaluation as appropriate. Additional evaluation may include one or more of the following: TST, IGRA, sign and symptom review, chest x-ray, or sputum collection. If the patient is immunosuppressed and no previous TB test is documented, an IGRA is recommended.

1. **Tuberculin Skin Test (TST)** - Please provide a 2-step TST for those at high risk that have no documentation of a previous TST: Administer 1st step TST today and read in 48-72 hrs, if the 1st step TST is positive, document the results in millimeters (mm)of induration and follow the evaluation steps for a positive TST. If the 1st step TST is negative document the results in mm of induration. Results of mm of induration, transverse diameter; if no induration write "0" mm. The TST interpretation* should be based on mm of induration as well as risk factors. Place a 2-step TST in one to three weeks after the first TST was read and recorded. The 2-step should be read in 48-72 hrs and then follow the documentation procedures as outlined above .

Date Given: _____ **Date Read:** _____
Result: _____ mm of Induration ***Interpretation:** Positive____ Negative____
Date Given: _____ **Date Read:** _____
Result: _____ mm of Induration ***Interpretation:** Positive____ Negative____

***TST Interpretation Guidelines (Please check all that apply).**

>5 mm is Positive:
- ☐ Recent close contacts of an individual with infectious TB
- ☐ Persons with fibrotic changes on a prior chest x-ray consistent with past TB disease
- ☐ Organ transplant recipients
- ☐ Immunosuppressed persons: taking ≥ 15 mg/d of prednisone for ≥ 1 month; taking a TNF-α antagonist
- ☐ Persons with HIV/AIDS

>15 mm is Positive: ☐ Persons with no known risk factors for TB disease

> 10 mm is Positive:
- ☐ Persons born in a high prevalence country or who resided in one for a significant amount of time
- ☐ History of illicit drug use
- ☐ Mycobacteriology laboratory personnel
- ☐ History of resident, worker or volunteer in high-risk congregate settings
- ☐ Persons with the following clinical conditions: silicosis, diabetes mellitus, chronic renal failure, leukemias and lymphomas, head, neck or lung cancer, low body weight (>10% below ideal), gastrectomy or intestinal bypass, chronic malabsorption syndromes
- ☐ Children < 4 years of age
- ☐ Children and adolescents exposed to adults in high-risk categories

2. **Interferon Gamma Release Assay (Please check the IGRA that is used)**
QFT-G ☐ QFT-GIT ☐ **Date Obtained:** _____
Result: ☐ Responsive (TB Infection Likely) ☐ Nonresponsive (TB Infection Unlikely) ☐ Indeterminate
T- Spot ☐ **Date Obtained:** _____
Result: ☐ Negative ☐ Positive ☐ Borderline/Equivocal
Other: _____ **Date Obtained:** _____ **Result:** _____

3. **Chest X-ray: (Required if TST or IGRA is positive)**
Date of Chest X-ray: _____ **Result:** ☐ Normal ☐ Abnormal
Abnormal Chest X-ray Interpretation: _____

4. **Sputum Collection: If the patient has a positive TST or IGRA and a productive cough > 3weeks, with or without hemoptysis,** please collect three (3) consecutive sputum, one early morning and all must be at least eight (8) hours apart with a minimum of 2 milliliters of specimen per tube.

1. Date Obtained	Smear Result:	Culture Result:	2. Date Obtained:	Smear Result:	Culture Result:
3. Date Obtained:	**Smear Result:**	**Culture Result:**			

An isolate on any positive mycobacterium cultures should be sent to the Missouri State Public Health Laboratory.

I have reviewed the above information with the patient and deemed: ☐ **No Further Evaluation Needed** ☐ **Further Evaluation is Needed**

_____ _____
Health Care Provider Signature (Required) Date:

All positive TST, IGRA, chest x-ray, smear and culture results suggestive of tuberculosis disease or latent tuberculosis infection should be reported to the Missouri Department of Health and Senior Services (fax number: 573-526-0235) or your local public health agency using this form. If you have any questions, please contact the Bureau of Communicable Disease Control and Prevention at 573-751-6113.

EMPLOYEE CONTACT & EMERGENCY INFORMATION

Employee Contact Info

Employee Name: _____

Home address: _____

City, State, Zip: _____

Primary Contact# (_____) _____ Secondary Contact# (_____) _____

Home Email_____

Emergency Contact Info

(1) Name: _____ Relationship: _____

Primary Contact# (_____) _____ Secondary Contact# (_____) _____

(2) Name: _____ Relationship: _____

Primary Contact# (_____) _____ Secondary Contact# (_____) _____

List all allergies here: _____

Physician Name: _____ (_____) _____

Hospital Preference: _____ (_____) _____

NOTE:
You are responsible for informing the FUN City Youth Academy principal if you have a medical condition that may require immediate first aid. Medical information is confidential. It is your decision and responsibility to inform others if you believe it necessary for your health and safety while at work.

I have voluntarily provided the above contact and emergency information and authorize FUN CITY Youth Academy representatives to contact any of the above on my behalf in the event of an emergency.

_____ _____

Employee Signature Date