Wellstar
AFFILIATED WITH MEDICAL COLLEGE OF GEORGIA

# VolunTeen
# 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 MCG Health Volunteer Services.**

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**

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**High School Counselor – please print.** The student listed above has applied for the Wellstar MCG Health Summer 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 fax or email completed form to Wellstar MCG Health Volunteer Services at 706-721-5196 or wellstarvolunteers@augusta.edu**