WEST HALDIMAND GENERAL HOSPITAL
AUXILIARY
Hagersville, Ontario

AUXILIARY VOLUNTEER SERVICES
INFORMATION AND CONSENT FOR VOLUNTEENS

Name:_____ Date:_____

Date of Birth:_____ Telephone:_____

Address:_____

Name of Parent or Guardian:_____

Family Doctor:_____ Telephone:_____

School:_____ Grade:_____

Signature of School Counsellor or Teacher_____

_____ has my permission to serve
(Full name of teen)
as a Volunteen

_____ _____
Signature of parent or guardian Date

_____ _____
Auxiliary Volunteer Coordinator Date