



Application for Student Volunteers

(minimum age is 14 years old)

Name Birth Date

Telephone Number

School Grade:

Name of Emergency Contact Telephone

Why are you interested in volunteering at the library?
.....
.....

List any previous volunteer or work experience:
.....
.....

Hobbies and interests:
.....
.....

Circle your preferred library branch: Central Glen Abbey Iroquois Ridge White Oaks Woodside

Circle the times you are available:

Monday	am	pm	evening	Friday	am	pm	evening
Tuesday	am	pm	evening	Saturday	am	pm	evening
Wednesday	am	pm	evening	Sunday	am	pm	evening
Thursday	am	pm	evening				

Please record the dates you would be unavailable to volunteer: (e.g. vacation)
.....
.....

Volunteers's Signature: Date:

I have read the information and understand my child's responsibilities as a volunteer at the Oakville Public Library. My child has my permission to volunteer with the Oakville Public Library.

Parent's Signature: Date:

Special Needs/Medical

To best serve the needs of all program participants, we require the following for leadership staff's awareness. Please choose the category that best describes the needs of the participant with special needs.

Participant Last Name (please print clearly)		First Name	Date of Birth: DD____ MM____ YY____
Home Phone		Business Phone	Main Contact Email Address:
CATEGORY	DESCRIPTION		
1	Participant has medical condition (non-life-threatening): Please identify:		
2	Participant has medical condition (life-threatening): Please note that for participants in this category a Medic-Alert or similar identity bracelet/necklace is mandatory. <input type="checkbox"/> Peanut allergy: Does participant carry Epi-Pen? _____ <input type="checkbox"/> Bee sting allergy: Does participant carry Epi-Pen? _____ <input type="checkbox"/> Other severe allergy? _____ Does participant carry Epi-Pen? _____ <input type="checkbox"/> Cardiac condition: _____ Does participant carry special medication? _____		
3	Participant has visual or hearing impairment, but no physical mobility impairment: <input type="checkbox"/> Visual impairment <input type="checkbox"/> Hearing impairment		
4	<input type="checkbox"/> Is extra support required at school? ____ <input type="checkbox"/> Is extra support/assistance required for basic care? ____ <input type="checkbox"/> Does disability affect the safety of the participant? ____ <input type="checkbox"/> Is participant currently associated with a support agency? ____ Support: <input type="checkbox"/> Will attend with own support <input type="checkbox"/> Support volunteer requested (subject to availability)		
5	Participant experiences physical mobility or mental challenges, or combination of both: <input type="checkbox"/> Physical impairment (describe condition and whether assistance is required for basic care) _____ _____ <input type="checkbox"/> Wheelchair/scooter is used: ____ Walking aid is used: _____ <input type="checkbox"/> Will special transportation be required for youth programs? <input type="checkbox"/> Mental challenges (describe condition and whether assistance is required for basic care). _____ _____ <input type="checkbox"/> Medical diagnosis is: <input type="checkbox"/> Down's Syndrome <input type="checkbox"/> Autism <input type="checkbox"/> Other:		
6	Other special considerations: _____ _____ _____		

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