



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 North Fulton Hospital 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

High School Counselor – please print. The student listed above has applied for the Wellstar North Fulton Hospital 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 email to: NFHVolunteers@Wellstar.org