



## School Counselor Recommendation Form

If not completed in correctly in full, the student will not be considered for the program.

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 Medical Center 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 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.**

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4. Any additional comments: \_\_\_\_\_  
\_\_\_\_\_

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Counselor's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Please email to: NFHVolunteers@Wellstar.org**  
**FAX: (770) 751.2953**