TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER
SCHOOL OF MEDICINE
VOLUNTEER SERVICES – EL PASO

Teen Volunteer Participation Authorization

I, _____, as parent/guardian of _____, a minor, authorize such minor to participate in the Teen Volunteer Program of the Texas Tech Health Sciences Center – El Paso**,** School of Medicine as prescribed by the designated representative of the Office of Volunteer Services. My authorization includes allowing such minor to participate in any necessary instruction and to render required number of service hours. I agree that the Texas Tech University Health Sciences Center – El Paso, School of Medicine is not responsible for the illness or accidental injuries to such minor that occur during participation in the Teen Volunteer Program.

AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT FOR MINOR

As parent/guardian of such minor, I certify that I have the power to consent to medical treatment of such minor. In my absence, I authorize physicians licensed under the provisions of the Texas Medical Practice Act on staff of the Texas Tech University Health Sciences – El Paso**,** School of Medicine to render, secure, or consent to emergency medical treatment deemed necessary for minor who, while participating in the Teen Volunteer Program is on the premises of the Texas Tech University Health Sciences Center – El Paso**.**

_____ _____

Signature of Parent/Guardian **Date**

Submit