632 West Main Street, Ephrata, Pennsylvania 17522
(717) 733-6600 www.EphtataC1oister.org

Parent/Guardian Approval and Release for Juvenile Volunteers at Ephrata Cloister Pennsylvania Historical and Museum Commission

I hereby authorize _____to participate as a volunteer at Ephrata Cloister as part of the **Student Historian Program** during the 2024/2025 school year. The Student Historian Program is open to high school students ages 14 to 18.

Participants must be the age of 14 on their start date of the program and be currently enrolled as a high school (level) student to participate in the Student Historian Program.

I understand that my son/daughter will be performing duties under the supervision of qualified staff or volunteers including the following:

Site Administrator - Elizabeth Bertheaud
Museum Educator 2 – Daniel Roe & Museum Educator 1 – Sophie Walters
Ephrata Cloister Associates Volunteers: Madelyn Marks & Suzanne Fisher

I confirm that _____is in good health and that any medical conditions that site personnel may need to be aware of are noted below.

I agree to indemnify and hold harmless the Commonwealth of Pennsylvania, the Pennsylvania Historical and Museum Commission (PHMC), and the Ephrata Cloister Associates (ECA) from damages to property or injuries (including death) to any person(s) and other losses, damages, expenses, claims, demands, suits and actions by any party against the Commonwealth, PHMC and/or ECA in conjunction with the work performed by _____. I understand that photographs of the student may be used for publicity purposes to benefit programs of the museum.

Parent/Guardian Signature _____ DATE: _____

Emergency contact information:

Parent/Guardian: _____

Address: _____ City: _____STATE: ____ ZIP: _____

Best Phone number to reach you in case of emergency: _____

Email: _____

Student Historian Participant Name: _____ AGE: _____ GRADE: _____

Preferred Name/Nickname: _____

School District or Educational Organization: _____

Email: _____ Phone: _____

Best/Preferred Method of Contact: _____

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List any allergies/medical problems, including those requiring maintenance medication (i.e. diabetes, seizure disorder) This information will be kept confidential and released only to medical professional in case of an emergency.

Medical Diagnosis/Allergies:_____

Medication: _____ Dosage: _____

Frequency of Dosage: _____

The purpose of this information is to ensure that medical personnel have details of any medical problems that may interfere with or alter treatment.