



Volunteer Information

Name: _____

Date of Birth: _____

Phone Number: _____

Email Address: _____

Camp/Event Name: Camp WANNAGOAGAIN

VOLUNTEER/COUNSELOR AGREEMENT AND RELEASE

I, the undersigned, agree to participate in Camp WANNAGOAGAIN— Sponsored by The Autism Project as a Volunteer or Counselor/ Counselor-in-Training-both referred to as “Counselor”. I understand that participation in camp/event may involve activities with a certain degree of risk and which may be physically, mentally, and emotionally demanding. I also understand that participation in these activities is entirely voluntary and requires me to abide by applicable rules and standards of conduct. Failure to comply with the rules or engaging in activity that potentially jeopardizes the safety of me or other participants, volunteers or personnel in camp/event may result in my dismissal. Furthermore, I agree, to the best of my ability, to follow all instructions and to ask for assistance if necessary. I acknowledge that I have carefully considered these risks and obligations and voluntarily accept them.

In case of an emergency, I understand that every effort will be made to reach one of the emergency contacts listed below. In the event such persons cannot be reached, I grant permission for camp/event to secure proper medical treatment for me, including hospitalization, anesthesia, surgery, or injections of medication.

Name of Emergency Contact: _____

Relationship: _____ **Phone:** _____

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Relationship: _____ **Phone:** _____

Background Check and Training

I agree to complete a national criminal background check.

Furthermore, I agree to participate in any required training for the event and Immunization Screenings.

Audio/Video/Photo Release

Signature required on the Community Authorization and Release for Photography/Audio and Videotaping/Broadcasting/Interviewing Document from Marketing and Communications.

General Waiver and Release

Being present and volunteering during this event could possibly involve potential risk including, but not limited to, personal injury or property damage. I understand that I am responsible for the safety of myself and any property I bring to this event. I agree, for myself, my heirs, executors and administrators, to release, indemnify, quit, hold harmless, and forever discharge Lifespan Corporation, [Click here to enter Lifespan Entity name](#), its affiliates and its and their respective governors, directors, trustees, officers, volunteers, employees and agents and all sponsoring businesses and organizations and their agents and employees, from any and all liability, obligations, penalties, claims, demands, judgments, executions, costs (including reasonable attorneys' fees), loss of services, expenses, compensation, actions and causes of action whatsoever, arising out of my participation in this event and related activities – whether it results from the negligence of any of the above or from any other cause.

Confidentiality: I understand that confidentiality is a critical component of camp/event. In general, Volunteers/Counselors may have access to limited basic health information of participants to the extent necessary to allow Volunteers/Counselors to support participants and other camp/event personnel in achieving the goals of the camp/event. I agree that such health information or any social information you may learn or observe about a participant, may only be used within camp/event for such purposes and may never be used or discussed outside of camp/event. If I am concerned that a participant may be at risk, either to themselves or others, or if I suspect the participant may be a victim of abuse, I will immediately notify the camp/event Medical Director, Program Director, or one of the camp/event nurses.

Role Model: I agree to lead by example by demonstrating enthusiasm and teamwork in camp/event activities, and by modeling how to listen to the experiences of others. I will act responsibly when interacting with participants in a group setting or one-on-one. I agree not to use drugs, alcohol, or other illegal substances while at the event. I agree that all cell phone use is prohibited except in an emergency.

Boundaries: I agree to maintain appropriate boundaries within the participant-staff relationship and to act responsibly. I agree that at no time shall a camp/event staff relationship with a participant be more than a friendship.

Contact outside the group: It is important to know the limits of availability and to have clear boundaries. I agree that contact via social networking sites is not permitted and may cause difficulty in maintaining boundaries if used. I will use common sense.

I HAVE READ AND I ACCEPT THE ABOVE TERMS AND CONDITIONS.

Print Name of counselor/volunteer

Date

Signature of counselor/volunteer

Date

CONFIDENTIALITY STATEMENT

I _____, as a volunteer at _____:

- Understand that it is my legal and ethical responsibility to maintain the confidentiality of all Patient Medical Records, Employee Information, Financial Information, Proprietary Information, And Confidential Information relating to Patients, Employees and others associated with the operation of The Autism Project in its legal course of business and Patient services.
- Agree not to disclose any such information or records to any person inside or outside of The Autism Project not having a need to know such information without proper authorization.
- Agree to discuss confidential information only in the workplace and only for job related purposes, and to refrain from discussing information outside of the workplace or within the hearing of other people who do not have a need to know about the information.
- Agree to protect and preserve the security of all paper documents bearing confidential information which are under my control and possession; and further understand that when such documents are no longer needed by me, their appropriate disposition is my responsibility.
- Recognize that unauthorized release of confidential information may make me subject to legal action and/or disciplinary action.
- Understand that any and all references to HIV testing, such as any clinical test, laboratory or otherwise used to identify HIV, a component of HIV, or antibodies or antigens to HIV, are specially protected and the unauthorized disclosure may make me subject to legal action and/or disciplinary action.
- Understand that my access to all electronic systems is audited regularly, and that unauthorized release of such information may make me subject to legal action and/or disciplinary action.
- Understand that I am not to share my log-in or user ID and/or password with anyone; and that any access to The Autism Project, Lifespan or its affiliated systems, to which I have access that are made under my log-in or user ID and password is my responsibility.
- Understand that if I have any doubts or concerns about the release of confidential information to any requestor, I will first reference Department Policy; and after which, if my doubts and concerns continue, will consult my supervisor.
- I hereby acknowledge that I have received HIPAA training.

I acknowledge that I have read and understand the above statements, have discussed them thoroughly with my supervisor, and have had all my questions answered and understand the important significance of my signature on this document.

Volunteer

Date

Supervisor

Date