Two Rock Elementary School
Volunteer Application Form

FOR OFFICE USE
Received By: _____
Date:_____
Assignment:_____
Superintendent/Principal:_____
TB Clearance _____

Thank you for your interest in volunteering at **Two Rock Elementary School.** Volunteers play a vital role in our school community. All volunteer applications are reviewed with consideration of current volunteer opportunities. We are committed to offering meaningful volunteer opportunities that enhance our school programs and address school and student needs. All volunteer placement decisions are made by the superintendent- principal, and will be based on student and staff needs, suitability for the role, and prior experience. In order for us to best place you, please complete the form below. All volunteers must provide current evidence of tuberculosis (TB) clearance. This form must be accompanied with the **Worker Vaccination Verification or Consent to Testing Form** prior to volunteering.

Personal Information

Name: _____ Mr. ☐ Mrs. ☐ Miss. ☐ Ms. ☐

Postal Address: _____

Telephone: (Home) _____ (Mobile) _____

Email: _____

If you are working with us as a volunteer and an emergency arises, whom should we contact?

Name: _____ Relationship: _____

Telephone: (Home) _____ (Mobile) _____

Skills and Interests

1. What is your motivation or interest in volunteering at Two Rock Elementary School?

2. Have you ever done any volunteer work before, either here or elsewhere?
Yes ☐ No ☐ If you answered yes, please tell us a little about the experience.

3. Do you have any particular skills or experience that you would like to utilize in your volunteer work with us? If so, please describe.

4. What kind of volunteer work interests you?

☐ Classroom Support
☐ Parents Association
☐ School Activities
☐ Project-Specific Volunteering (please specify) _____ ☐ Office
☐ Other (please specify) _____

5. When are you available for voluntary work? Hours per week _____ ☐ Totally Flexible

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Morning							
Afternoon							
Evening							

References

Name: _____ Relationship: _____

Place of Work: _____ Position or role: _____ (If applicable)

Telephone: (Home) _____ (Mobile) _____

E-Mail: _____

Name: _____ Relationship: _____

Place of Work: _____ Position or role: _____ (If applicable)

Telephone: (Home) _____ (Mobile) _____

E-Mail: _____

Signature_____Date

Please note that volunteers who participate in field trips may be required to submit additional paperwork and complete a fingerprinting process. Volunteers are subject to all Mandated Reporting laws.

Two Rock Union School District
5001 Spring Hill Road ▪ Petaluma, CA ▪ 94952
Phone: (707) 762-6617 ▪ Fax: (707) 762-1923
www.trusd.org

WORKER VACCINATION VERIFICATION OR CONSENT TO TESTING FORM

Worker Type: □ Employee □ Independent Contractor □ Volunteer[1]

Worker Name and Title: _____

Worker Date of Birth: _____

Worker Worksite: _____

Consistent with the California Department of Public Health Order dated August 11, 2021, and the County of Sonoma Health Order dated August 23, 2021, the _____ School District ("District") is required to determine our workers' vaccination status by September 24, 2021.

Vaccine Received (select one):
□ Moderna □ Pfizer □ Johnson & Johnson □ Other[2]: _____

Date of Dose 1: _____ **Date of Dose 2 (if applicable): _____**

Please select one of the following modes of proof of vaccination:

- Your COVID-19 Vaccination Record Card (issued by the Department of Health and Human Services Centers for Disease Control & Prevention or WHO Yellow Card), which includes name of person vaccinated, type of vaccine provided and date last dose administered;
- A copy of a Vaccination Record Card as a separate document;
- A photo of a Vaccination Record Card stored on a phone or electronic device;
- Documentation of COVID-19 vaccination from a health care provider; OR
- A digital record that includes a QR code that when scanned by a SMART Health Card reader displays to the reader client name, date of birth, vaccine dates and vaccine type;
- [For Independent Contractors] Documentation of vaccination from one of your other contracted employers who follow these same vaccination records guidelines and standards.

[1] "Volunteer" includes one-time volunteers like monitors and chaperones that spend time with students.
[2] Write in name of WHO-approved vaccine that is accepted in the United States (e.g. AstraZeneca).

Worker Authorization to Use and Disclose Medical Information

I authorize the District, consistent with applicable medical confidentiality laws, to use and disclose information regarding my COVID-19 vaccination status or COVID testing results to District's HR, management, or supervisors, for only legitimate, non-discriminatory business purposes where my vaccination status is necessary for the District to make work-related decisions authorized by or in order to comply with federal, state, or local laws or regulations that takes a worker's vaccination status or test results into account. I understand that I have the right to receive a copy of this authorization upon request. I hereby attest that I am signing this authorization voluntarily**.**

Check one of the following:

□ Fully Vaccinated: By checking this box and by signing below, I acknowledge, understand, authorize, and agree with the statements above, and hereby attest that I am fully vaccinated against COVID-19, I have provided proof, and I authorize the District to use and only disclose my COVID-19 vaccination status as outlined above.

□ Consent to Test: I have not provided proof and as a result, I understand I am ***required and hereby consent*** **to** participate in regular COVID-19 testing, as outlined by the Public Health Order(s) or as required by the District. I consent to the collection of biological specimens form me in connection with such testing. I authorize and consent to the release of my test results to medical professionals, medical facilities, or third parties including medical professionals and governmental authorities as required by applicable law. I must also observe all other infection control requirements, including masking. I understand that I may undergo District-approved testing on my own and provide the results to the District, or I will participate in the District-sponsored testing [if applicable]. I may revoke permission to release my information as agreed to above at any time, in writing to my supervisor. *By signing below, I acknowledge, understand, authorize, and agree with the above statements.*

Employee Signature: _____ Date: _____

Department Verification:

□ *By checking this box and by signing below, I acknowledge that I have visually verified the mode of proof provided by the employee.*

□ *Proof was not provided.*

Validated by (print name): _____ Date: _____

Signature: _____

This form is to be kept in a confidential medical file that is separate from the employee's personnel file.[3]

[3] The ADA requires that all medical information about a particular employee be stored separately from the employee's personnel file. (See https://www.eeoc.gov/wys