Cabell Huntington Hospital | St. Mary's Medical Center
Rivers Health | Hoops Family Children's Hospital

VolunTeen Parent/Guardian
Consent and Release of Liability Form

My son / daughter, _____, has my permission to serve as a Marshall Health Network VolunTeen. As the parent/guardian of the above-named student, I will read the literature that is provided to my child so that I know what will be expected of him/her. Volunteering may include observing patients in a healthcare setting and observing medical, laboratory, and/or business procedures. I further understand that Marshall Health Network and their facilities offers medical services for the care and treatment of a wide range of illnesses, diseases and injuries, including but not limited to, such infectious diseases as tuberculosis, hepatitis, COVID-19 and HIV and that there is a risk, however slight, that my son/daughter might be inadvertently exposed to such diseases at the Hospital. I attest that my child is free from communicable diseases and will be able to provide proof of immunizations as requested by Employee Health

I do hereby fully and forever, remise, release and discharge Marshall Health Network (defined herein to include, but not be limited to, Marshall Health Network, Cabell Huntington Hospital Inc., Hoops Family Children's Hospital, HIMG, Rivers Health, St. Mary's Medical Center, St. Mary's Medical Management their officers, directors, members, partners, affiliated organizations, employees, agents, and representatives) of and from any responsibilities of injury or accident as a result of the volunteering experience. Any medical expenses incurred as a result of injury or accident will be my responsibility. I understand that in case of a medical emergency, every attempt will be made to contact me before medical action is taken. However, this document is my consent as parent or guardian for emergency treatment and/or procedures necessary for my son/daughter by the professional staff.

I hereby, for myself and for my child, and intending to be legally bound, release, discharge and relieve Marshall Health Network (as defined above) of and from any and all claims whatsoever of any nature as a result of his/her volunteering and all related activities.

I release and give my permission to Marshall Health Network, its agents and employees to interview and/or take photographs and/or video of my child in his/her capacity as VoluTeen for current and future use in news/feature stories; promotional publications, videos or displays; and the Marshall Health Network family of sites.

_____
Print Parent/Guardian Name

_____ _____
Signature Parent/Guardian Name Date