LISLE 202
COMMUNITY UNIT SCHOOL DISTRICT

Volunteer Release and Waiver of Liability Form

Important – Lisle CUSD #202 appreciates the assistance of its volunteers. As a volunteer, you will play a role in assisting the High School and our community. But before you may begin your volunteer assignment, you will need to acknowledge that you have agreed to the terms of this release. You should read it carefully before signing it.

Waiver and release of claims. I understand that during the course of my volunteer activities with Lisle CUSD #202, hazards may arise. I assume the risk of injury and I fully and completely release, waive, and discharge Lisle CUSD #202, including its officers, employees, agents, and affiliated entities, from any and all liability, losses, injuries, death, damage, and any other claims connected in any to my volunteer activities for Lisle CUSD #202. This release includes any claim that may arise due to first aid, medical treatment, or other service rendered to me. Additionally, I agree pay for the costs of any claims, including attorney's fees, that are made or threatened against Lisle CUSD #202 or its officers, employees, agents, and affiliated entities arising out of any of my volunteer activities. I agree that this release is intended to be as broad and inclusive as permitted by the laws of Illinois, which govern the application and interpretation of this release. I understand that should any part of this release be ruled invalid by a court, the other parts will remain valid and continue to be in effect

Volunteer status. I understand that I am an unpaid volunteer for Lisle CUSD #202. I waive all claims for compensation from Lisle CUSD #202 for any services I performed in connection with my volunteer assignment at Lisle CUSD #202. When performing volunteer services, I understand that I am not an employee of Lisle CUSD #202 and I am not entitled to any employee benefits. Lisle CUSD #202 does not have any responsibility to provide any health, medical, disability, or any other insurance coverage for me. It is my responsibility as a volunteer to ensure that I have insurance coverage if I want it. I understand that I will not be entitled to workers' compensation coverage.

Photographic release. I grant to Lisle CUSD #202 the unlimited right to use photographic images and video or audio recordings of me that are made by Lisle CUSD #202 or others during my volunteer assignment for Lisle CUSD #202, including any royalties, proceeds, or other benefits from the use of these photographs or recordings.

Background check. I understand that a criminal history and background check may be obtained prior to my appointment as a volunteer. My signature below certifies that I agree to a criminal history check and agree to provide Lisle CUSD #202 with any other information required to perform a criminal history or background check.

Our policies. I agree to follow and abide by all of Lisle CUSD #202 policies, including those that forbid discrimination and harassment.

Term of assignment. After my volunteer assignment begins, I understand that Lisle CUSD #202 may terminate the assignment at any time for any reason.

_____	_____	_____
Volunteer's Signature	Printed Name	Today's Date

Illinois Department of
DCFS
Children & Family Services

ACKNOWLEDGEMENT OF MANDATED REPORTER STATUS

I, _____, understand that when I am employed as a
(Employee Name)

_____, I will become a mandated reporter under the
(Type of Employment)
Abused and Neglected Child Reporting Act [325 ILCS 5/4]. This means that I am required to report or cause a report to be made to the child abuse Hotline number at 1-800-25-ABUSE (1-800-252-2873) whenever I have reasonable cause to believe that a child known to me in my professional or official capacity may be abused or neglected. I understand that there is no charge when calling the Hotline number and that the Hotline operates 24-hours per day, 7 days per week, 365 days per year.

I further understand that the privileged quality of communication between me and my patient or client is not grounds for failure to report suspected child abuse or neglect, I know that if I willfully fail to report suspected child abuse or neglect, I may be found guilty of a Class A misdemeanor. This does not apply to physicians who will be referred to the Illinois State Medical Disciplinary Board for action.

I also understand that if I am subject to licensing under but not limited to the following acts: the Illinois Nursing Act of 1987, the Medical Practice Act of 1987, the Illinois Dental Practice Act, the School Code, the Acupuncture Practice Act, the Illinois Optometric Practice Act of 1987, the Illinois Physical Therapy Act, the Physician Assistants Practice Act of 1987, the Podiatric Medical Practice Act of 1987, the Clinical Psychologist Licensing Act, the Clinical Social Work and Social Work Practice Act, the Illinois Athletic Trainers Practice Act, the Dietetic and Nutrition Services Practice Act, the Marriage and Family Therapy Act, the Naprapathic Practice Act, the Respiratory Care Practice Act, the Professional Counselor and Clinical Professional Counselor Licensing Act, the Illinois Speech-Language Pathology and Audiology Practice Act, I may be subject to license suspension or revocation if I willfully fail to report suspected child abuse or neglect.

I affirm that I have read this statement and have knowledge and understanding of the reporting requirements, which apply to me under the Abused and Neglected Child Reporting Act.

_____
Signature of Applicant/Employee

_____
Date

CANTS 22
Rev. 8/2013

Office of the Director
406 E. Monroe Street • Springfield, Illinois 62701
www.DCFS.illinois.gov

EMPLOYEE EMERGENCY CONTACT FORM

Name _____

Department _____

Personal Contact Info:

Home Address _____

City, State, ZIP _____

Home Telephone # _____ Cell # _____

Emergency Contact Info:

(1) Name _____ Relationship _____

Address _____

City, State, ZIP _____

Home Telephone # _____ Cell # _____

Work Telephone # _____ Employer _____

(2) Name _____ Relationship _____

Address _____

City, State, ZIP _____

Home Telephone # _____ Cell # _____

Work Telephone # _____ Employer _____

Medical Contact Info:

Doctor Name. _____ Phone # _____

Dentist Name _____ Phone # _____

☐ I have voluntarily provided the above contact information and authorize Lisle CUSD 20[illegible] and its representatives to contact any of the above on my behalf in the event of an emergency.

Employee Signature _____ Date _____