



---

Rockwall County Helping Hands  
Student Volunteer Application

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell: \_\_\_\_\_

e-mail address: \_\_\_\_\_

School Attending: \_\_\_\_\_ Grade: \_\_\_\_\_

Days that you are available to volunteer: \_\_\_\_\_

Specific Hours: \_\_\_\_\_

Is there a program area that interests you more than another?

Community Clinic

Emergency Assistance

Thrift Store

Parents Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Emergency Phone: \_\_\_\_\_

Are you taking any medications that we should know about in case of an emergency?

List:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any health conditions that we should notify emergency personnel about if necessary?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Applicant Signature

\_\_\_\_\_  
Date