

IF MINOR, CHECK BOXES.

**VOLUNTEER HOLD HARMLESS AND INDEMNIFICATION AGREEMENT**

I, \_\_\_\_\_ ( a minor) wish to perform services at \_\_\_\_\_ for the Board of County Commissioners of Seminole County, Florida in the \_\_\_\_\_ as a volunteer.

I undertake to perform these services for the experience and self-satisfaction I will gain from this public service. I understand that I am not, nor will I be, a County employee nor will I be eligible for any of the benefits of a County employee except to the extent State law mandates volunteer participation in a benefits program.

(We, \_\_\_\_\_ and \_\_\_\_\_, Parent(s) or guardian(s) of \_\_\_\_\_, wish our child/ward to have the benefit of performing services for the County.)

In consideration of the County’s permission to perform volunteer services, I, for myself and my assigns ( and we, as parents or guardians, for ourselves and our assigns) do hereby release and discharge Seminole County, its agents, officers and employees from any and all claims, demands, grievances, and causes of action of every kind whatsoever, including, but not by way of limitation, all liability for property damages and personal injury of every kind, nature or description arising or which may hereafter arise from said permission, volunteer’s performance of services or volunteer’s presence on the work site.

I/We hereby indemnify and hold harmless Seminole County for any and all claims, demands and causes of action of every kind and nature arising out of said permission, volunteer’s performance of services, or volunteer’s presence on the work site.

\_\_\_\_\_  
Volunteer’s Signature

\_\_\_\_\_  
Division Manager

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Address

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

\_\_\_\_\_  
IF MINOR, Signature of Parent(s) or Guardian(s)



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**EMERGENCY MEDICAL AUTHORIZATION FORM**

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I, \_\_\_\_\_  
(Volunteer, or Parent or Guardian of Minor Volunteer)

Parent/Guardian of \_\_\_\_\_

Born on \_\_\_\_\_,  
(Insert Date)

Do hereby give my consent to **Seminole County Leisure Services** to secure and authorize such emergency medical treatment as the above name might require while under the supervision of said care provider. I also agree to pay all the costs and fees contingent on emergency medical care or treatment for this person as secured or authorized under this consent. Note: Every effort will be made to notify the parents/son/daughter/guardian, etc in case of an emergency. In the event of an emergency, it would be necessary to have the following information:

Physician's Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

Volunteer Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature (If Under age 18) \_\_\_\_\_ Date \_\_\_\_\_