

SCHOOL YEAR: _____

**SAN DIEGO UNIFIED SCHOOL DISTRICT
SCHOOL VOLUNTEER APPLICATION**

DATE _____ DISTRICT SPONSOR _____ SCHOOL _____

FULL NAME _____
(FIRST) (MIDDLE) (LAST)

ADDRESS _____ DATE OF BIRTH _____
(STREET) (CITY) (ZIP) MO/DAY/YR

Gov Issued ID Type _____

HOME PHONE _____ E-MAIL _____ ID# _____

NOTIFY IN CASE OF EMERGENCY _____
(NAME) (PHONE)

CURRENT EMPLOYMENT _____
(EMPLOYER'S NAME) (ADDRESS) (PHONE)

VOLUNTEER EXPERIENCE _____

PERSONAL REFERENCE _____
(NAME) (ADDRESS) (PHONE)

Please check whether you are a new or returning SDUSD volunteer, New Returning

Are you also a volunteer at another SDUSD school? YES NO

If yes, please indicate the school(s): _____

Do you have any criminal charges pending against you? YES NO

Have you ever been convicted* of a felony or misdemeanor? YES NO

Have you ever been convicted* of a sex, drug or weapon related offense? YES NO

Are you required to register as a sex offender under Penal Code 290.95? YES NO

*Conviction includes a finding of guilty by a court in a trial with or without a jury or a plea or verdict of guilty.

If "YES," please explain: _____

I agree to follow ALL COVID-19 health and safety protocols, complete the daily screening requirements or ClearPass, and wear a face mask. YES NO

Parent Volunteers: Please check whether you plan to drive for a field trip during the school year, YES NO

Please list the name(s) of your child(ren): _____

For security reasons, a background check will be conducted by school site staff and/or SDUSD School Police Services. Volunteer assignments may be terminated if service is unsatisfactory or no longer needed by the school district. You may not volunteer if you are required to register as a sex offender under California law.

I give my permission to have my personal and professional references researched and hold the district and any individuals providing the district with information harmless. By signing my name below, I declare under penalty of perjury, that all the information on this application is true and correct. I also declare that I have read and agree to follow the "Volunteer Code of Conduct."

Volunteer Signature: _____ Date: _____

TO BE COMPLETED BY VOLUNTEER COORDINATOR:

TB test completed (Date): _____

Volunteer category (check appropriate box and indicate date cleared):

Category B Megan's Law database check - cleared _____

Category C SDUSD School Police background check - cleared _____

Category D Fingerprinting - cleared _____

Type of volunteer (check if appropriate):

Parent OASIS Volunteer
 Community Rolling Reader/EAR CalWORKS
 Partner College Student Other _____

Volunteer service ended (date): _____

Reason for leaving:

Child no longer at school
 Moved Illness
 Employment Requested to Leave
 Other: _____

VOLUNTEER APPLICATIONS SHOULD BE FILED AT THE SCHOOL SITE WITH TB AND BACKGROUND CLEARANCE DOCUMENTATION AND SAVED FOR 3 YEARS



VOLUNTEER CODE OF CONDUCT

(This document defines the district's expectations for all school volunteers.)

As a volunteer, I agree to abide by the following code of volunteer conduct:

1. Immediately upon arrival, I will sign in at the main office or the designated sign-in station.
2. I will wear or show volunteer identification whenever required by the school to do so.
3. I will use only adult bathroom facilities.
4. I agree to never be alone with individual students who are not under the supervision of teachers or school authorities.
5. I will not contact students outside of school hours without permission from the students' parents.
6. I agree not to exchange telephone numbers, home addresses, e-mail addresses or any other home directory information with students for any purpose unless it is required as part of my role as a volunteer. I will exchange home directory information only with parental and administrative approval.
7. I will maintain confidentiality outside of school and will share with teachers and/or school administrators **any** concerns that I may have related to student welfare and/or safety.
8. I agree to not transport students without the written permission of parents or guardians or without the expressed permission of the school or district and will abide by District Administrative Procedure# 4586 when transporting students.
9. I will not disclose, use, or disseminate student photographs or personal information about students, self, or others.
10. I agree to follow the district procedure for screening of volunteers.
11. I agree to notify the school principal if I am arrested for a misdemeanor or felony sex, drug or weapon related offense.
12. I agree only to do what is in the best personal and educational interest of every child with whom I come into contact.
13. I agree to follow ALL COVID-19 health and safety protocols, complete the daily screening requirements or ClearPass, and wear a face mask.

I agree to follow the Volunteer Code of Conduct at all times or cease volunteering immediately.

Print Name

Signature

Date

Phone Number

Adult Tuberculosis (TB) Risk Assessment Questionnaire

Must be administered by a licensed health care provider (physician, physician assistant, nurse, nurse practitioner)

Employee Name: _____ Employee ID Number: _____

Date of Birth: _____ Date of Risk Assessment: _____

History of positive TB test or TB disease Yes No

If yes, a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire,

If there is a "Yes" response to any of the questions #1-5 below, then a tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) should be performed, A positive test should be followed by a chest x-ray, and if normal, treatment for TB infection considered,

Risk Factors	
1. One or more signs and symptoms of TB (prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue) Note: A chest x-ray and/or sputum examination may be necessary to rule out infectious TB	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Close contact with someone with infectious TB disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Foreign-born person (Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Traveler to high TB-prevalence country for more than 1 month (Any country other than the United States, Canada, Australia, New Zealand, or a country in Western or Northern Europe.)	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. Current or former resident or employee of correctional facility, long-term care facility, hospital, or homeless shelter	<input type="checkbox"/> Yes <input type="checkbox"/> No

Signature: _____ Date: _____

Adult Tuberculosis (TB) Risk Assessment Questionnaire Certificate of Completion

(Must be signed by the health care provider completing the risk assessment and/or examination)

The above named patient has submitted to a tuberculosis risk assessment, and if tuberculosis risk factors were identified has been examined and determined to be free of infectious tuberculosis.

Health Care Provider Signature Date

Health Care Provider Name Physician License Number

Office Address: Street City State Zip Code

Telephone Fax