



Eugene School District 4J
Volunteer Interest Form

Name: _____
Last First Middle (full name required)

Address: _____ City: _____ Zip: _____

Telephone #: _____
Home Work Message/Cell/Pager

E-mail address: _____

School/s for volunteer placement: _____

Student's Name: _____ Grade: _____ School: _____
 Name: _____ Grade: _____ School: _____
 Relationship to student: _____

Choices for Volunteering (Please indicate area of interest)

Instruction	Library	Special Projects
<input type="checkbox"/> General Classroom	<input type="checkbox"/> Clerical/shelving	<input type="checkbox"/> Arts & Crafts
<input type="checkbox"/> Computer	<input type="checkbox"/> Storytelling	<input type="checkbox"/> Bulletin Board
<input type="checkbox"/> Language Arts Tutor	Cafeteria	<input type="checkbox"/> Calligraphy
<input type="checkbox"/> Mathematics	<input type="checkbox"/> Lunchroom Facilitator	<input type="checkbox"/> Display Case
<input type="checkbox"/> Physical Education	<input type="checkbox"/> Food Server	<input type="checkbox"/> Drama
<input type="checkbox"/> English Language Learners Tutor	Office	<input type="checkbox"/> Music
<input type="checkbox"/> Bi-lingual Tutor/Interpreter	<input type="checkbox"/> General Duties	<input type="checkbox"/> Child Care
_____ (language/s)	<input type="checkbox"/> Telephoning	<input type="checkbox"/> Field Trips
<input type="checkbox"/> Talented & Gifted Program (TAG)	Other	<input type="checkbox"/> Fund-Raising
<input type="checkbox"/> Vocational Education	<input type="checkbox"/> Volunteer Coordinator	<input type="checkbox"/> Teacher Appreciation
<input type="checkbox"/> Special Needs Education	<input type="checkbox"/> Health Screening	
<input type="checkbox"/> Publishing Center	<input type="checkbox"/> Health Room Helper	
<input type="checkbox"/> SMART Reading Program	<input type="checkbox"/> Playground	
<input type="checkbox"/> Other _____		
<input type="checkbox"/> I would be interested in being a presenter on these topics: _____		

Emergency Information (list two people to contact in case of emergency):

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Primary Doctor's Name: _____ Phone: _____

Do you have a hospital preference? Yes No Hospital: _____

Do you have a medical condition, or are you taking medication/s we should know about in case of an emergency? Yes No

If yes, please explain: _____