SAN GABRIEL UNIFIED SCHOOL DISTRICT
VOLUNTEER PROGRAM

TO: HUMAN RESOURCES

RE: VOLUNTEER SERVICES

DATE _____

SCHOOL _____

NAME (print) _____

OFFICIAL DOCUMENTATION NEEDED TO PROCESS ALL VOLUNTEERS

1. Volunteer application
2. Copy of valid photo identification
3. Completed Megan's Law Declaration
4. Completed TB risk assessment/examination (AB 1667)
5. Worker's Compensation Form
6. Level 3 Volunteer – Department of Justice/FBI criminal background check

Please return all required documents to the School Office

School Office Use Only

( ) Volunteer App ( ) Photo ID ( ) Megan's Law Compliance Form

( ) TB Clearance Date _____ ( ) Worker's Comp Form

( ) Orientation/Training Date _____

District Office Use Only

( ) Personal Vehicle Use & DMV Form ( ) DOJ/FBI Check Date _____

Approved _____ Denied _____

Signature _____
Human Resources

VOLUNTEER AGREEMENT

Coolidge Elementary School

Dear Coolidge Volunteer,

Your dedication and assistance is greatly appreciated by the students and staff of Coolidge Elementary School. Our goal is that your time at Coolidge will be enjoyable and rewarding for you, the students, and the staff. We would like to ask you to follow some guidelines while volunteering on campus. Thank you for your commitment!

Sincerely,
Coolidge Staff

As a Coolidge Volunteer:

- ✓ I agree to sign in at the main office and obtain a visitor badge. For safety purposes, this will enable students and staff to identify me as a volunteer.
- ✓ I agree to follow the rules and procedures of the area in which I am volunteering.
- ✓ I agree to maintain the confidentiality of all students, teachers, staff, and volunteers that I assist and/or observe. Personal issues and concerns (behavioral, social, and/or academic) must be discussed privately with the appropriate staff member(s).
- ✓ I realize that my attendance is important, and I will make every attempt to provide 24 hours notice if I am unable to fulfill my prearranged commitment.
- ✓ I agree to refrain from using my cell phone while volunteering with students.

Name: _____

Signature: _____

Date: _____

SAN GABRIEL UNIFIED SCHOOL DISTRICT
VOLUNTEER PROGRAM

Thank you for your interest and active participation as a volunteer. Volunteers are very important to the San Gabriel Unified School District. You are essential to the fine programs that are offered to our students. Please take a moment to review the guidelines and screening procedures for all volunteers.

Volunteer Guidelines

All volunteers are required to:

- Act in accordance with district policies and regulations, as well as individual site requirements
- Complete and return all required forms each school year (excludes TB) prior to volunteering
- Be approved by School Administration/District prior to volunteering
- Sign in and sign out at Front Office each day on campus
- Wear a Visitor Badge at all times while on school grounds
- Maintain the confidentiality of each student

Volunteer Screening Procedures

Volunteers are required to pass a tuberculosis (TB) risk assessment or examination – which is good for 4 years. If you are in need of a TB risk assessment, complete the assessment checklist and submit it with the volunteer application. If risk factors are identified, you will be contacted by our district nurse and will need a TB examination completed by your health care provider.

Volunteers – Level 1

No application or screening (TB test or background) is required for volunteers who WILL NOT be working directly with students or whose duties are primarily conducted off campus. Examples may include volunteers performing classroom projects for teachers at home or assisting with school wide events where there are supervising staff present at all times (i.e. - school carnivals, book fairs).

Volunteers – Level 2 (Staff Supervision Present)

Volunteers who have limited and/or direct contact with students with SGUSD staff present at all times must pass the sex offender screening. This screening is required to be conducted annually. Examples may include classroom volunteers and office volunteers.

Volunteers – Level 3 (No Staff Supervision Present)

Volunteers whose work duties involve direct student contact in a district-sponsored student activity program where work with students may occur outside the direct supervision of SGUSD staff must obtain both a Department of Justice and FBI criminal background check through the district. Examples may include mentors, volunteer coaches and extracurricular activities such as cheer and drill team.

The District reserves the right to screen volunteer applicants for any record of criminal history.

SAN GABRIEL UNIFIED SCHOOL DISTRICT
VOLUNTEER APPLICATION
_____ School Year

This information will be kept confidential

PLEASE PRINT

SCHOOL_____ VOLUNTEER LEVEL_____

NAME_____

(First) (M.I.) (Last)

ADDRESS_____

HOME PHONE_____ CELL/WORK PHONE_____

PREFERRED CONTACT METHOD: ( ) Home Phone ( ) Cell/Work ( ) Email_____

VALID FORM OF IDENTIFICATION (PLEASE CIRCLE ONE)

VALID DRIVERS LICENSE • STATE ID • SCHOOL ID • PASSPORT

(ATTACH COPY OF PHOTO IDENTIFICATION)

IN CASE OF EMGERGENCY, PLEASE CONTACT: _____

(Name & Phone Number)

Have you ever been convicted of a felony? ( ) Yes ( ) No
If yes, please explain on the back of this form.

Have you ever been convicted of a sex or drug-related offense or crime of violence ( ) Yes ( ) No
If yes, please explain on the back of this form.

Are you required to register as a sex offender under Penal Code 290 ( ) Yes ( ) No

The San Gabriel Unified School District believes every student should be able to enter a learning environment free from crime, violence, drugs and abuse. In the interest of our students, staff and community, the District reserves the right to conduct a criminal background check of school volunteers as permitted by law.

I am offering my services to the San Gabriel Unified School District as a volunteer without compensation and without right to health insurance benefits. I understand that either the District or I may terminate this volunteer relationship at any time without notice.

I certify under penalty of perjury that I have not been required to register as a sex offender pursuant to Penal Code Section 290. I understand that, in accordance with District policy, school administrators will verify this information via the California Megan's Law database.

I affirm that all the above information is true and complete.

_____ _____

Signature Date

_____ Approved _____ Denied _____

Principal Signature

SAN GABRIEL UNIFIED SCHOOL DISTRICT

Declaration of Compliance with Megan's Law Requirement for Volunteers

To be completed by Volunteer

SCHOOL_____ DATE_____

NAME_____

ADDRESS_____

PHONE NUMBER_____

*****FOR SCHOOL OFFICE USE ONLY*****

Results of Megan's Law Check

www.meganslaw.ca.gov

Megan's Law Website check for this applicant was completed by the principal/designee on:

DATE_____

Results of the website check:

_____ The applicant's name **did** appear on the Megan's Law Website

_____ The applicant's name **did not** appear on the Megan's Law Website

Principal/designee's signature below indicates compliance with Megan's Law requirements.

_____ _____

Signature Date

_____

Name (Print)

SAN GABRIEL UNIFIED SCHOOL DISTRICT
SAN GABRIEL, CALIFORNIA

DATE: _____

TO: Designated Volunteer

FROM: Business Services Department

SUBJECT: WORKERS' COMPENSATION COVERAGE FOR VOLUNTEERS

This is to advise you that the San Gabriel Unified School District has adopted a Board Resolution to cover authorized volunteers for the purpose of Workers' Compensation Insurance. Workers' Compensation benefits will be provided in accordance with the California Labor Code for any injury or illness sustained while engaged in the services as a _____ at _____.
(Description of Job) (Name of School)

Should you be injured while serving in this capacity, and therefore covered under our Workers' Compensation Self-Funded Program, we need to advise you that you would not be eligible to file any civil claim, action or proceeding.

By signing this document, you acknowledge that Workers' Compensation benefits will be the sole remedy and agree to waive any civil liability.

Name_____ Signature_____
(Please Print)

Volunteer for_____ Location_____

****

Approved_____ Date_____
(Principal's Signature)

****

Approved _____ Denied _____ Date:_____
(Asst. Superintendent. Business Services will make determination and sign)

Revision 8/12/09

School Staff & Volunteers: Tuberculosis Risk Assessment

Job-related requirement for childcare, pre-K, K-12, and community colleges

The purpose of this tool is to identify **adults** with infectious tuberculosis (TB) to prevent them from spreading TB. Use of this risk assessment is required in the California Education Code, Sections 49406 and 87408.6 and the Health and Safety Code, Sections 1597.055 and 121525-121555.

The law requires that a health care provider administer this risk assessment. A health care provider, as defined for this purpose, is any organization, facility, institution or person licensed, certified or otherwise authorized or permitted by state law to deliver or furnish health services. Any person administering this risk assessment is to have training in the purpose and significance of the risk assessment and Certificate of Completion.

Name of Employee/Volunteer Assessed for TB Risk Factors: _____

Assessment Date: _____ **Date of Birth:** _____

History of Tuberculosis Infection or Disease (Check appropriate box below)

☐ Yes

If there is a documented history of positive TB test (infection) or TB disease, then a symptom review and chest x-ray (if none performed in previous 6 months) should be performed at initial hire by a physician, physician assistant, or nurse practitioner. Once a person has a documented positive test for TB infection that has been followed by an x-ray that was determined to be free of infectious TB, the TB risk assessment (and repeat x-rays) is no longer required. If an employee or volunteer becomes symptomatic for TB, then he/she should seek care from his/her health care provider.

☐ **No** (Assess for Risk Factors for Tuberculosis using box below)

Risk Factors for Tuberculosis (Check appropriate boxes below)

If any of the 5 boxes below are checked, perform a Mantoux tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA). A positive TST or IGRA should be followed by a chest x-ray, and if normal, treatment for TB infection considered. (Centers for Disease Control and Prevention (CDC). *Latent Tuberculosis Infection: A Guide for Primary Health Care Providers*, 2013)

☐ **One or more signs and symptoms of TB:** prolonged cough, coughing up blood, fever, night sweats, weight loss, excessive fatigue.

Evaluate for active TB disease with a TST or IGRA, chest x-ray, symptom screen, and if indicated, sputum AFB smears, cultures and nucleic acid amplification testing. A negative TST or IGRA does not rule out active TB disease.

☐ **Close contact** to someone with infectious TB disease at any time

☐ **Foreign-born** person from a country with an elevated TB rate

Includes countries other than the United States, Canada, Australia, New Zealand, or a country in Western and Northern Europe. IGRA is preferred over TST for foreign-born persons

☐ **Consecutive travel or residence of ≥ 1 month** in a country with an elevated TB rate

Includes countries other than the United States, Canada, Australia, New Zealand, or a country in Western and Northern Europe.

☐ Volunteered, worked or lived in a **correctional or homeless** facility

Re-testing with TST or IGRA should only be done in persons who previously tested negative, and have new risk factors since the last assessment.

FILL OUT BACKSIDE

Certificate of Completion
Tuberculosis Risk Assessment and/or Examination

To satisfy job-related requirements in the California Education Code, Sections 49406 and 87408.6 and the California Health and Safety Code, Sections 1597.055, 121525, 121545 and 121555.

First and Last Name of the person assessed and/or examined:

_____

Date of assessment and/or examination: _____mo./_____day/_____yr.

Date of Birth: _____mo./_____day/_____yr.

DISTRICT NURSE CAN SIGN

The above named patient has submitted to a tuberculosis risk assessment. The patient does not have risk factors, or if tuberculosis risk factors were identified, the patient has been examined and determined to be free of infectious tuberculosis.

X_____
Signature of Health Care Provider completing the risk assessment and/or examination

Please print, place label or stamp with Health Care Provider Name, Address (include Number, Street, City, State, and Zip Code):

Telephone/FAX: