



BUDDY CLUB VOLUNTEER PACKET

Buddy Club is a partner event with UCP of Stanislaus to promote socialization, peer inclusion and activities for teens and young adults with disabilities. This once a month event provides a space for teens and young adults to hang out among friends with organized activities and opportunities to just relax and enjoy a movie or make a craft project. Light snacks are provided.

Special Diet concerns:

We would recommend bringing your own snack

Volunteer Opportunities:

We need 5-8 volunteers 14 yrs and up to help us encourage socialization and participation in Buddy Club and to provide a true peer experience.

Program Location:

Buddy Club takes place at UCP of Stanislaus, 4265 Spyres Way, Suite 2, Modesto, CA 95356

This location is ADA compliant and fully accessible. We can accommodate 60 participants safely. Location may change.

How do I learn what to do?

Before we begin, we will have a quick overview of Buddy Club duties and safety measures with all volunteers. ***We ask that volunteers arrive at least 15 minutes before our start time.***

What do I bring?

Volunteers may bring a snack and beverage or may enjoy what we provide. Dress comfortably and ready to have fun. Some days, we may get messy, but we will let you know first!

If you have required service hours for school or other projects, we are happy to sign off if you bring your form!

PLEASE MAKE SURE YOUR PARENT/GUARDIAN SIGN IN THE APPROPRIATE MARKED SECTIONS.

Keep this page for your reference



**BUDDY CLUB
VOLUNTEER PACKET**

Applicant's Name: _____

DOB: _____ *Age: _____ Gender: M F

***Please note: If you are 18 years or older you must complete a background check authorization-NO EXCEPTIONS- ALLOW 2 DAYS FOR CLEARANCE. You cannot volunteer until your background process has cleared.**

Address: _____ City: _____ Zip: _____

Email **(REQUIRED)**: _____

Most communication done through Email

Phone: (H): _____ (W): _____ (C): _____

Have you volunteered for Society before? If yes, for what programs/events?

What school/organization are you with? _____

Parent/Guardian/**Emergency Contact Name(s)**: _____

Relationship: _____ Phone: (H): _____ (C): _____

Experience working with differently abled individuals? YES NO

Have you volunteered with Society and/or UCP in the past? YES NO

Do you have any:

CPR Training: Yes No

First Aid Training: Yes No



Nondiscrimination Policy

Society for disABILITIES (the Society) is a 501(c) (3) nonprofit organization. The Society is committed to providing an environment and programs that are free from discrimination because of race, color, religion, creed, national origin, ancestry, disability, gender, sexual orientation, or age. The Executive Director has issued the following policy stating the Society's views in this matter:

- We will strictly follow program procedures that will ensure equal opportunity for all people without regard to race, color, religion, creed, national origin, gender, sexual orientation, age, ancestry, marital status, disability, veteran or draft status.
- Thoroughly investigate instances of alleged discrimination and take corrective action if warranted.
- Be continually alert to identify and correct any practices by individuals that are at variance with the intent of the Nondiscrimination Policy.
- Make reasonable accommodations wherever necessary for all employees or applicants with disabilities, provided the individual is otherwise qualified to safely perform the duties & assignments connected with the job & provided any accommodations made do not require significant difficulty or expense.
- Achieve understanding & acceptance of the Society's policy on Equal Employment Opportunity by all staff & volunteers and by the communities in which the organization operates.

Zero Tolerance to Sexual Harassment in the Workplace

- Unwanted jokes, gestures, offensive words on clothing, and unwelcome comments and repartee.
- Touching and any other bodily contact such as scratching or patting a coworker's back, grabbing an employee around the waist, or interfering with an employee's ability to move.
- Repeated requests for dates that are turned down or unwanted flirting.
- Transmitting or posting emails, texts, or pictures of a sexual or other harassment-related nature.
- Displaying sexually suggestive objects, pictures, or posters.
- Playing sexually suggestive music.
- Quid pro quo...anything of sexual nature suggested in exchange of "You do something for me and I'll do something for you".
 - "I'll get you fired if you don't have sex with me, or go on a date with me, or touch me, etc."
 - A job benefit of any kind that is linked to unwelcome sexual advances.
- Treating one sex differently than the other.
- Any sexual advance or sexually derogatory comments making an employee uncomfortable.
- There shall be no retaliation against any employee reporting a case of Sexual Harassment.

I have read and received a copy of this document.

Print Name: _____

Signature: _____ Date: _____



Volunteer Waiver and Release of Liability

I request to be allowed to volunteer in the **Buddy Club Program**, and agree to the following:

1. I acknowledge and fully understand that I and/or the minor participant will be participating in activities associated with the Buddy Club program that may involve risk of personal injury, including permanent disability and death. I also acknowledge that there may be other risks not known to me or not reasonably foreseeable at this time.
2. I assume all the foregoing risks and accept personal responsibility for the damages following such injury, permanent disability or death.
3. Myself and my family release, waive, discharge and promise not to sue Society for disABILITIES, United Cerebral Palsy Association (UCP), Inc. of Stanislaus County, its volunteers, staff, executive director, and board of directors, and other participants of Buddy Club for any personal injury, property damage, or other damages that may arise from my participation in the Buddy Club program, regardless of whether such injury or damage is caused by negligence or carelessness.
4. I agree that photographs and/or my or my child's name may be published in, or used by Society for disABILITIES and/or UCP of Stanislaus County and any of the media or mass communication (including newspapers, magazines, television, pamphlets, brochures, newsletters, reports, etc.) without any liability on the part of Society for disABILITIES or UCP of Stanislaus County.
5. I have talked to my physician, who has acknowledged, that I or my child are physically capable to engage in the Buddy Club program with or without the use of adaptive equipment. I have given an accurate description of my or my child's disability and medical needs on the participant application.
6. I agree that the staff and volunteers of Buddy Club, Society for disABILITIES and/or UCP of Stanislaus County may authorize emergency medical treatment for myself, or for my child, up to and including emergency hospitalization and surgery. I give the Society and volunteer(s) the right to determine the appropriate medical facility/provider in the absence of the parent. I agree to be personally responsible for any related medical expenses. 4. I agree that photographs/videos and/or my name, may be published in, or used by Society for disABILITIES and any of the media or mass communication (including newspapers, magazines, television, pamphlets, brochures, newsletters, reports, etc.) without any liability on the part of Society for disABILITIES.

I/WE HAVE READ THE ABOVE WAIVER AND RELEASE, UNDERSTAND THAT I/WE HAVE GIVEN UP SUBSTANTIAL RIGHTS BY SIGNING IT, HAVE NOT CHANGED IT ORALLY, AND SIGN IT VOL-UNTARILY.

***If participant is under 18 years of age or is unable to legally give effective consent, Parent/Guardian MUST sign below**

Volunteer Name:

(PLEASE PRINT CLEARLY)

Volunteer Signature: _____ **Date:** _____

Parent Signature if Volunteer is under 18 years old:

(PLEASE PRINT CLEARLY)



Volunteer Background Check Authorization Form
(Only to be filled out by Volunteers who are 18 years or older)

I, _____ (applicant name), hereby authorize Society for disABILITIES to obtain information pertaining to any charges and/or convictions I may have had for violation of municipal, county, state or federal laws. This information will include, but not be limited to, allegations regarding and convictions for crimes committed upon minors and will be gathered from any law enforcement agency of this state or any state or federal government, or from third-party providers of information originally obtained from law enforcement or court records.

I understand that I will be given an opportunity to challenge the accuracy or any information received that appears to implicate me in criminal activities. To facilitate this challenge, I will be told the nature of the information and the agency from which it was obtained. It will be my responsibility to contact that agency. I further understand that until the Society for disABILITIES receives notification from that agency clearing me, my application will be deferred.

As an applicant for a staff/volunteer position, I hereby attest to the truthfulness of the representations I have made. Except as I have disclosed, I have not been found guilty of, or entered a plea of nolo contendere or guilty to any offense. Further, other than for the offenses I have disclosed, I have not had a finding of delinquency or entered a plea of nolo contendere or guilty to a petition of delinquency under the juvenile laws of this state or any other state.

I understand that I must be truthful and, if any statement I have made is found to be false, I will be denied the position for which I am making application or, if already accepted, terminated from my position.

Applicant Name: _____
(PLEASE PRINT CLEARLY)

Applicant Signature: _____ Date: _____

Date of Last Background Check: _____ First Time Applying: Yes No

Full Name of Applicant: _____
(PLEASE PRINT CLEARLY, INCLUDING MIDDLE NAME)

DOB: _____ Gender: M F Race: _____

Email: _____

Address: _____ City: _____ Zip: _____

Social Security Number: _____ - _____ - _____

