

Faith Communities For Disaster Recovery

MEDICAL RELEASE FORM (Youth) Faith Communities for Disaster Recovery

I, _____ / _____ authorize _____
(Parent or legal Guardian of Volunteer Participant) (another adult on trip)

to consent to any necessary examination, anesthetic, medical diagnosis, surgery, or treatment and/or hospital care rendered to him/her under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine by the state in which they practice, during the duration of the trip identified below.

Trip or Activity: _____ Volunteer work with Faith Communities for Disaster Recovery _____

Dates of Trip: _____

Participant's Physician: _____ Telephone _____

Allergies and Medications: _____

Participant's Medical Insurance: _____ / _____
(Carrier) (Policy No.)

Carrier's Telephone No: _____

Signature of Parent or Legal Guardian: _____ Date: _____

Witness: _____

Signature of Participant: _____ Date: _____

Social Security No: _____

Witness: _____

Faith Communities For Disaster Recovery

MEDICAL RELEASE FORM (Adult) Faith Communities for Disaster Recovery

I, _____ consent to any necessary examination,
(Volunteer Participant)
anesthetic, medical diagnosis, surgery, or treatment and/or hospital care rendered to me under the general or special supervision and on the advice of any physician or surgeon licensed to practice medicine by the state in which they practice, during the duration of the trip identified below.

Trip or Activity: Volunteer work with Faith Communities for Disaster Recovery

Dates of Trip: _____

Participant's Physician: _____ Telephone _____

Allergies and Medications: _____

Participant's Medical Insurance: _____ / _____
(Carrier) (Policy No.)

Carrier's Telephone No: _____

Signature of Participant: _____ Date: _____

Social Security No: _____

Witness: _____

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MEDICAL INFORMATION FORM

Please complete the following and give to mission team leader:

1. Name: _____ Social Security No: _____

2. Blood type: _____

3. Information about any prescriptions I use: _____

4. I am allergic to: _____

5. Name of contact person in USA: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Relationship to me: _____

6. My health insurance company is: Policy number: _____

7. Contact person: _____

8. Physical limitations or concerns: _____

9. I am a diabetic: Yes No

10. I have a history of seizures: Yes No

11. Please provide other helpful health information: _____

12. I consider myself healthy enough to fulfill my responsibilities on the mission team.
 Yes No

Signature (parent or guardian if minor): _____ Date: _____