VOLUNTEER MEDICAL INFORMATION

I understand and acknowledge that in the event of an emergency it is the responsibility of my team leader to consent to and obtain necessary medical treatment on my behalf if I am unable to act and that Faith Village is not responsible for obtaining or consenting to any medical treatment on my behalf. I further hold harmless Faith from any liability for acting or failing to act in obtaining or consenting to any such medical treatment.

(PLEASE PRINT):

Name _____
(first) (middle) (last)

Address _____
(street) (city) (state) (zip)

EMERGENCY CONTACTS:
Name: _____
(first) (middle) (last)

Relationship: _____

Phone: _____
(with area code) (day) (evening)

Name: _____
(first) (middle) (last)

Relationship: _____

Phone: _____
(with area code) (day) (evening)

YOUR PHYSICIAN:

Name: _____

Phone: _____
(with area code)

MEDICAL CONDITION:

List any medical conditions you have (asthma, diabetes, epilepsy, etc.):

List any allergies or allergic reactions to medications:

List any medications you are currently taking:

Date of your most recent Tetanus shot:
_____

Other pertinent medical information:

_____

_____

MEDICAL INSURANCE:

Company _____

Policy No._____

Please attach a copy of your Insurance Card (front and back)

_____
Signature of Participant Date

_____
Signature of Parent/Guardian if under 18 Date

FOR YOUR PROTECTION, PLEASE KEEP A COPY OF THIS FORM WITH YOUR TEAM AT ALL TIMES.