

Adult and Minor Volunteer Consent for Medical Treatment for Local Relief Efforts Short Form

The information on this Adult and Minor Volunteer Health History and Authorization and Consent for Medical Treatment must be provided in order for any person to participate in any Bethany Community Church **Relief Effort** or **Housing**.

VOLUNTEER AND EMERGENCY CONTACT INFORMATION

Volunteer Name: _____ Male Female
Date of Birth: _____ Phone: _____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Driver's License #: _____ License State: _____
E-mail address: _____

If volunteer is a minor:

Custodial Parent/guardian: _____ Home Phone: _____
Cell of other: _____ Work Phone: _____
If parent/guardian is not available in an emergency, contact: _____
Relationship: _____ Phone Numbers: _____

Emergency Contact:

Name: _____
Address: _____
Work: _____ Cell or other: _____

INSURANCE INFORMATION:

Insurance Carrier of plan name: _____ Group # _____
Plan # _____ ID # _____
Name of Insured: _____ Relationship to Volunteer: _____

HEALTH RESTRICTIONS:

Do you have any current health problems or medical conditions? Yes No
If yes, please describe all health problems or medical conditions, _____

Have you had a Tetanus/Diphtheria inoculation in the last five (5) years? Yes (M/D/Y) _____ No

Name of family Physician: _____ Phone: _____

VOLUNTEER OR PARENT/GUARDIAN AUTHORIZATION AND CONSENT FOR MEDICAL TREATMENT

This Health History and Consent is correct and complete. The Volunteer identified above has permission to engage in all Volunteer Program activities except as expressly stated in writing. I hereby give permission to Bethany Community Church to provide emergency and routine first aid, and seek emergency medical treatment including, without limitation, ordering tests or any other procedure recommended by any physician or medical provider. I agree to the release of any records necessary for insurance/medical purposes. I hereby give permission to Bethany Community Church to arrange necessary related transportation for Volunteer in the event of an emergency. If I cannot be reached in an emergency, I hereby give permission to all physicians, related medical providers and any health care facility to secure and administer treatment, including hospitalization, for the Volunteer identified above. **NO ALCOHOL, ILLEGAL DRUGS OR WEAPONS ALLOWED ON PROPERTY. VIOLATION OF THIS IS GROUNDS FOR IMMEDIATE REMOVAL. ALL BAGS ARE SUBJECT TO SEARCH. ALL VOLUNTEERS ARE SUBJECT TO CRIMINAL BACKGROUND CHECKS.**

Signature of volunteer or parent/guardian: _____
Printed Name: _____ Date: _____