

VOLUNTEER MEDICAL HISTORY/RELEASE

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 the Episcopal Dioceses of New York, New Jersey & Easton are not responsible for obtaining or consenting to any medical treatment on my behalf. I further hold harmless the Episcopal Diocese of New York, New Jersey & Easton from any liability for acting or failing to act in obtaining or consenting to any such medical treatment.

I hereby give my team leader listed below my permission to discuss my medical condition with any appropriate medical authority involved in my care during this trip to volunteer with Sandy Recovery.

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

Address: _____
(street)

_____ (city) (state) (zip code)

Team Leader(s) Signature(s) _____

Church/Organization: _____

Emergency Contacts:

Name: _____ (first & last) _____ (relationship)

Phone: (____) _____ (day) (____) _____ (evening)

Name: _____ (first & last) _____ (relationship)

Phone: (____) _____ (day) (____) _____ (evening)

Your Physician:

Name: _____

Phone: (____) _____

Medical Conditions;

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 & for what:

Date of your most recent Tetanus shot: _____

Other pertinent medical information:

Medical Insurance: Bring your insurance cards or copies with you.

Company: _____ Policy No. _____

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

It is not necessary to return this form to the Episcopal Diocese of New York, New Jersey or Easton.

