



**HEALTH INSURANCE / MEDICAL RELEASE FORM
VOLUNTEERS UNDER AGE 18**

PLEASE PRINT

Name of volunteer participant: _____ Birth Date ___/___/___
Preferred Name: _____

Circle one: Male / Female Name of parish or school: _____

Home Address: _____

City: _____ State & Zip: _____ Phone: (____) _____

Date of this trip to Nazareth Farm: _____

Emergency contact person: _____ Relation to you: _____

Day phone: (____) _____ Evening Phone: (____) _____

Known Allergies: _____

Dietary Restrictions (vegetarian, food allergies, etc.): _____

Current Medications: _____

Will you need assistance with your medication(s)? Please specify.

Blood Type (if known): _____ Date of most recent TETANUS BOOSTER: ___/___/___

Date of most recent physical exam: ___/___/___ (must be within the last 12 months)

Limitations to physical labor: _____

(You will **NOT** be made to perform any task you are unable to do for whatever reason.)

Emotional/Psychological condition(s) and/or concerns: _____

Complete name of Insurance Company: _____

Policy Number/Group Number: _____

Name on insurance card: _____ Cardholder's date of birth _____

Cardholder's social security number: _____ Employer's name _____

If an accident occurs mail the claim to: _____

(If you do NOT have health insurance, please contact us at the above number).

FOR PARENT OR GUARDIAN:

During the volunteer's week here at Nazareth Farm, she or he will ride in vans to and from worksites. Because parish/school groups are broken up into work groups, it is very likely that your child will ride in a van driven by an adult chaperone other than your child's group leader. All vans will only be driven by adult chaperones during the week.

I, the undersigned parent or guardian of _____ (participant's name) a minor, do hereby authorize the adult staff members of Nazareth Farm as my agents, to consent to any examinations, x-ray, anesthetic, medical, or surgical diagnosis or treatment and hospital care which is deemed advisable by a qualified physician or local hospital. Nazareth Farm agrees to contact the undersigned as soon as possible if an emergency should arise. I will assume responsibility for fees incurred by such an emergency. In addition, I certify that the above information is correct and give permission for the release of medical records to the attending physician.

Signature of Parent or Guardian: _____

Printed name of Parent or Guardian: _____

Address: _____

Daytime Phone: _____ Evening Phone: _____