



P.O. Box 274

Pence Springs

West Virginia

24962

304.445.7143

bethlehemfarm.net

Health Insurance/Medical Release Form

Volunteers 18 and older

Please Print

Name of volunteer participant: _____ Birth Date ____/____/____

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

Home Address: _____

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

School Address: _____

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

Dates of this trip to Bethlehem 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: _____

Insurance Information:

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.)

I, _____, do hereby accept financial responsibility for any medical fees that occur either during or after my stay at Bethlehem Farm. In addition, I certify that the above information is correct.

Signature of Volunteer: _____

Printed name of Volunteer: _____