2012 Medical Release Form for Volunteers & Visitors

Volunteer's Full Name	

Citizenship	**USA**	**Passport #**	

Emergency Contact Information

Emergency Contact (1)		**Relationship**	

Phone Number(s)	*Home* *Office* *Cellular*	**Other Contact Information (fax, email, etc.)**	

Emergency Contact (2)		**Relationship**	

Phone Number(s)	*Home* *Office* *Cellular*	**Other Contact Information (fax, email, etc.)**	

Medical History

Have you ever, or do you currently have any of the following conditions?		
		Please Specify:
	Asthma	
	Exercise induced asthma	
	Diabetes	
	Seizure disorder	
	Heart disease	
	Kidney problems	
	Liver problems	
	Tuberculosis	
	Migraine headaches	
	Digestive problems	
	Depression	
	Hypoglycemia	
	Panic attacks	
	Physical disabilities	
	Eating disorders	
	Surgeries	
	Hospitalizations	
	Other	

Check or list all allergies you have:		*Are you allergic to any medication?*		
	Bees		Sulfas	
	Dogs/cats		Penicillin	
	Hayfever/grasses/pollen		Other (specify)___________________________	
	Smoke			
	Other ___________________________________		Do you currently smoke?	NO

Primary Care Physician		*Medical Insurance*	
Name:		Company Name:	
Address:		Policy Number:	
Phone:			
Fax:			

List any prescription medications you are currently taking, and the conditions for which the medication has been prescribed:

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List any special directions to be followed in case of an emergency:

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I have provided the information above in connection with my application to volunteer for, or visit, the Fabretto Children's Foundation/Asociación Familia Padre Fabretto (FCF/AFPF) programs and projects in Nicaragua. In signing this form below, I authorize FCF/AFPF and any of their agents or employees to take any and all actions that they may deem necessary or appropriate, at my expense, in order to treat and respond to any accident, illness, injury or other medical emergency that I may experience during my volunteer participation. I understand that such treatment and response may include transporting me, at my expense, to a location appropriate for medical treatment. I understand that in the event of an accident, illness, injury or other medical emergency FCF/AFPF shall use its best efforts to promptly inform the person(s) I have listed on this form, but I agree that FCF/AFPF shall not have any liability for failure to notify such person(s).

I ____ , certify that I have personally completed this form. The information contained here is complete, and I have not withheld any medical or mental health information. If any aspect of my health profile changes between submitting this form and my departure, I will notify FCF/AFPF in writing. By signing this form, I release, acquit, discharge and covenant to hold harmless FCF/AFPF and its representatives from all actions, damages or liabilities arising from the treatment of any illness, injury, or medical emergency incurred by my volunteer participation. It is the intention of this release the FCF/AFPF and its representatives incur no liability whatsoever while attempting to meet all medical needs that I may require during my participation.

Volunteer Signature:		Date:	

Parent's or Guardian's Signature:*		Date:	

* Signature needed if volunteer is under 21 years of age on the date of signature