

VOLUNTEER MEDICAL/WAIVER QUESTIONNAIRE

MEDICAL QUESTIONNAIRE

1.) Are you (or your child) presently taking any medications or carrying any emergency medication?

YES _ NO _

Medication Dose Condition Being Treated

- A.
- B.
- C.

2.) Are you (or your child) allergic to any type of medication?

YES_ NO_

If yes, what medication:

3.) Do you (or your child) have any physical handicap or illness which would prevent you/your child from participating in normal rigorous activity?

YES_ NO_

If yes, please explain:

CONSENT & CERTIFICATION

I understand that I will be notified in the case of a medical emergency involving my child. However, in the event that I cannot be reached, I authorize the calling of a doctor and the providing of necessary medical services in the event my child is injured or becomes ill.

I understand that neither _____ Church, the Southern District of the C&MA OR New Hope Church, Gretna, LA will be responsible for medical expenses incurred, but that such expenses will be my responsibility as parent/guardian. I agree to notify the Church in the event of any health changes which would restrict my child's participation in any normal youth or children's activities. I also understand that the adult supervisors reserve the right to restrict my child from any activity that they do not feel is within the physical capabilities of my child. I the undersigned being the parent or legal guardian of the child named herein ("the child"), do hereby consent to the participation of my child in all of the scheduled activities of "Hurricane Katrina Relief Efforts in New Orleans, LA". The work includes cooking/serving/cleanup, site maintenance, unloading trucks, giving out items, debris removal/cleanup/home repairs, and any other activities that are associated with this church hurricane relief assistance. Further, I certify that my child is physically fit and adequately trained to participate in such events except as previously noted.

Signature_____ Date_____

Signature of Parent/Guardian_____ Date_____

Insurance Company_____ Member Services #_____

Mailing Address_____

Insurance Policy & Group # _____ Member ID#_____

Emergency Contact_____ Phone_____

Dr. Name_____ Phone_____

TURN IN TO GROUP LEADER