VOLUNTEER HEALTH INFORMATION

The purpose of this form is to provide relevant information to assist in a potential medical emergency. New Day does not accept any responsibility or liability in the event of a medical emergency, but we will endeavor to 1) contact your emergency contact person, 2) assist in providing to an appropriate medical facility of your choice, and 3) provide a copy of this form to you and/or the medical professional managing your care.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Volunteer Signature (Parent Signature if under 18) Date

|  |  |  |  |
| --- | --- | --- | --- |
| Name of Volunteer: |  | Date of Birth: |  |
| Home Address: |  | Citizenship: |  |
| City/State/Zip |  | Passport #: |  |
| Country |  | Phone: |  |

Emergency Contact: Please name the person who has the authority to make medical decisions on your behalf.

|  |  |
| --- | --- |
| Name: |  |
| Relationship: |  |
| Phone # including country code: |  |
| Alt phone # including country code: |  |

Secondary Contact: Please name a person who can assist us in reaching your primary emergency contact if we are unable to.

|  |  |
| --- | --- |
| Name: |  |
| Relationship: |  |
| Phone # including country code: |  |
| Alt phone # including country code: |  |

Travel Insurance (Required)

|  |  |
| --- | --- |
| Company |  |
| Policy Name/Type |  |
| Policy # |  |
| Contact phone #: |  |

Medical Information

Allergies: If none, please write NONE.

|  |  |  |
| --- | --- | --- |
| Food Allergies | Drug Allergies | Other Allergies (insect, hayfever) |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

If any allergies, do you carry an epi pen? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medications: If none, please write NONE.

|  |  |  |
| --- | --- | --- |
| Medication | Purpose | Dosage/Schedule |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Date of last tetanus shot: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other relevant medical history: Check any that apply and explain below.

|  |  |  |  |
| --- | --- | --- | --- |
| Heart disease |  | Glasses |  |
| High blood pressure |  | Contact lenses |  |
| Asthma/respiratory |  | Hearing device |  |
| Diabetes |  | Other |  |
| Epilepsy/seizures |  |  |  |

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