10910 E. State Road 28-67
Albany, IN 47320
765.212.8521
terratimeoffice@gmail.com

VOLUNTEER MEDICAL RELEASE

Date: _____

Name of Volunteer: _____ Date of Birth: _____

Address: _____
(Street, City, State, Zip)

Contacts for Emergencies

List contacts in order of who to contact first.

1) Name: _____ Cell: _____

2) Name: _____ Cell: _____

3) Name: _____ Cell: _____

Medical Information and Special Considerations

Check any that apply.

- o No specific medical or behavioral condition
- o Food allergies – please specify _____
- o Non-food allergies –please specify _____

Medications

List below all medications, including EpiPen, asthma inhaler, over-the-counter or nonprescription drugs, taken regularly.

Past Medical Treatment

Please list any major medical treatment within the last year:

Health Insurance / Physician

Insurance Company: _____

Policy/Group # _____ Participant ID Number: _____

Physician's Name: _____ Phone: _____

Dentist's Name: _____ Phone: _____

PERMISSION TO SECURE TREATMENT

An employee certified in First Aid, CPR, EpiPen and asthma inhaler assistance is always on location. They will take whatever emergency medical measures are deemed necessary for your protection and safety within their training.

In the event of any emergency, I authorize TerraTime, INC to secure from any licensed hospital, physician and/or medical personnel any treatment deemed necessary for my immediate care and agree that I will be responsible for payment of any and all medical services rendered. I understand that this authorization includes transportation by ambulance if necessary to the nearest medical treatment facility.

To the best of my knowledge, the information provided is correct. I understand that I am asked to advise TerraTime should there be any changes to my physical, psychological, or behavioral conditions.

I have read, understood, and fully authorized this medical release.

_____ _____

Signature of Volunteer Date

_____

Printed Name