

JAMESTOWN NEW HORIZONS

Volunteer's Authorization For Emergency Medical Treatment Form

VOLUNTEER'S NAME _____

ADDRESS _____
 (Street) (City) (Zip)

HOME PHONE () _____ WORK PHONE () _____

PHYSICIAN'S NAME _____ PHONE () _____

PREFERRED MEDICAL FACILITY _____

HEALTH INSURANCE CO. _____ POLICY NO. _____

Describe any medical condition requiring special precautions or treatment, and any medications and dosage.

() CONSENT PLAN:

In the event emergency medical aid/treatment is required due to illness or injury while on the premises, I authorize JAMESTOWN NEW HORIZONS to secure and retain medical treatment and transportation if needed. This authorization includes x-ray, surgery, hospitalization, medication and any treatment procedure deemed "life saving" by the physician. *This provision will only be invoked if the contact below is unable to be reached.*

Contact _____ Phone () _____ Relationship _____

Date _____ Consent Signature _____

() NON-CONSENT PLAN:

I do not give my consent for emergency medical treatment/aid in the case of illness or injury during the process of volunteering at Jamestown New Horizons or while on the premises. In the event emergency treatment/aid is required, I wish the following procedures to take place:

Date _____ Non-Consent Signature _____

I, _____ ("Volunteer"), am over 18 years of age and fully competent to sign this Emergency Medical Form, which I have read and understand, or, if under age, Volunteer has obtained the signature of his/her parent/guardian, who, by such signature, represents he/she has read and understands this Form. Although every effort will be made to avoid any accident, Volunteer understands NO LIABILITY can be accepted by JAMESTOWN NEW HORIZONS, in the event such accident may occur. In the event any provision of this Form is determined to be unenforceable, all other provisions shall remain in full force and effect.

If 18 years or under: DATE OF BIRTH _____ Minimum age: 16 years

PARENT/GUARDIAN Name _____ Phone () _____

Person who is authorized to give temporary assistance or care in absence of parent or guardian:

Name _____

Phone () _____ Relationship _____

SIGNATURE OF PARENT/GUARDIAN _____

SIGNATURE OF VOLUNTEER, IF OVER AGE 18 _____