

Date of last tetanus shot: _____

Physical Impairments/Limitations: _____

Other: _____

Personal Physician:

Name: _____

Address: _____, _____, _____

Phone: _____

Health Insurance Coverage:

Company: _____ Policy Number: _____

Insurance Agent: _____ Phone: _____



PARENT RELEASE FOR TREATMENT OF A MINOR CHILD

I, _____ am the parent or legal guardian

having custody of _____, a minor child. As such parent or legal guardian, I hereby authorize and appoint an adult in whose care the minor child has been entrusted or a duly authorized agent of Habitat for Chautauqua Area, Inc., Silver Creek Satellite as my agent to act for me with respect to my minor child, and in my name in any way I could act in person, to make any and all decisions for me with respect to my minor child, concerning my minor child's personal care, medical treatment, hospitalization, and health care and to require, withhold or withdraw any type of medical treatment or procedure, including X-ray examination, anesthetic, medical or surgical diagnosis or treatment which may be rendered to my minor child under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the state in which treatment is sought. My agent shall have the same access to my minor child's medical records that I have, including the right to disclose the contents to others.

Witness: _____ Parent or Guardian: _____

Witness: _____ Parent or Guardian: _____

In case of emergency, please contact:

Name: _____ Relation: _____

Address: _____, _____, _____

Phone: (H) _____ (W) _____

The following information may be needed by any hospital or medical practitioner not having access to the Volunteer's medical history:

Allergies (**M**edicine, food, etc.): _____

Medication being taken: _____