

REGISTRATION and MEDICAL RELEASE FORM

2010 HOPE (Housing Outreach Project Express)

Attention Work Crew Leaders:

- Keep the original, notarized form in the vehicle in which you travel at all times.
- Be sure that a copy has been given to the HOPE Center Coordinator.

Attention Participants:

Complete all the information requested below. You and your parents (if you are a student participant under the age of 18) need to sign the back of the form† and have the form notarized in the space provided. Mrs. Casey is a Notary Public and has her seal in the school office. Staple a copy of your medical insurance card to this form.

Have you ever participated in HOPE before: Yes:___ No:___ Birth date ____/____/____ Gender: _____

Name _____ Social Security # _____
(Last) (First) (MI) (Used only for medical treatment)

Address _____ () _____
(Street) (City) (State) (Zip) (Phone Number)

E-Mail address _____ Occupation _____ Last tetanus shot (date) _____

IN AN EMERGENCY, CONTACT:

Name _____ Day Phone () _____
(Circle One) Parent Spouse Legal Guardian Other Evening Phone () _____
Cell Phone () _____

Address of Above _____
(Street) (City) (State) (Zip)

Other relative or responsible person:

Name _____ Relationship _____ Day Phone () _____
Evening Phone () _____
Cell Phone () _____

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

Medications you currently take (prescribed and OTC; please list all, this is extremely important!)

Medication(s) you CANNOT take _____

Any allergies/special health problems or concerns: _____

Medical Insurance Co. _____ Phone () _____

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

Policy# _____ Policy Holder's ID# _____ Your relation to Policy Holder _____

Doctor's Name _____ Phone () _____

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

†Medical information written on this form will only be used in the event that medical treatment is needed. It will not be used for any other purpose.

In the event of an emergency or non-emergency situation in which medical treatment is required as a result of participation with the HOPE Project, every reasonable effort will be made to contact the persons listed above. If unsuccessful in contacting the persons listed, consent/permission is given for treatment by competent medical personnel.

Further, and unless specified otherwise, consent/permission is hereby given to all accompanying adult volunteer leaders on this trip to hospitalize, secure proper treatment for, and to order injection, anesthesia, or surgery (under recommendation of qualified medical personnel). If possible, the adult contact person for your group should make final decisions in cooperation with medical personnel.

I understand that the HOPE Project does not carry accident or medical insurance on participating volunteers. I agree that my insurance company will be used for such medical care expenses and I am aware that I may be billed by the medical provider for any medical treatment expenses not covered by my insurance. I understand that if I do not have medical insurance coverage that I am responsible for the payment of any medical bills.

Signature (Participant) – **I certify that I am 18 years of age or older.**

Date

Signature (**Minor** Participant – volunteer under the age of 18)

Date

Signature of Adult for Minor/Relationship (i.e. parent, guardian, etc.)

Date

(Name of parent/guardian of minor participant **OR** Name of Participant 18 years or older) appeared before me,
_____, a notary public of _____ County
in the State of _____, the persons whose signatures appear above and with whom I am
personally acquainted and acknowledged that he/she executed the within instrument for the purposes therein
contained.

Witness my hand and official seal this _____ day of _____, 2010

Notary Public

My Commission expires _____.

NOTARIZATION IS REQUIRED FOR ALL HOPE PROJECT VOLUNTEERS!