



VIRGINIA BAPTIST DISASTER RESPONSE

Please complete the form below;
Read and sign the release.
We are grateful you can respond!!

VOLUNTEER CONTACT & RELEASE FORM

2828 Emerywood Parkway | Richmond, VA 23294 | 833.374.3577 | www.BGAVDR.org

PARTICIPANT & FAMILY INFORMATION

Participant Name: _____
FIRST MIDDLE LAST

Nickname: _____ Gender: M F Birthdate: ____ / ____ / ____

Phone Number: (____) _____ (____) _____
HOME CELL

E-mail Address(es): _____

Address: _____
STREET APT #

_____ CITY STATE ZIP

Your Church: _____

EMERGENCY CONTACT INFORMATION [PARENT/GUARDIAN IF UNDER 18]

Contact #1 Name: _____ Relationship to Participant: _____

Phone Numbers: (____) _____ (____) _____ (____) _____
HOME CELL WORK

Contact #2 Name: _____ Relationship to Participant: _____

Phone Numbers: (____) _____ (____) _____ (____) _____
HOME CELL WORK

PERMISSION AGREEMENT AND SIGNATURE

Volunteer (if volunteer is under 18, then parent/guardian) agrees to the following: I understand this work entails a risk of physical injury and certify I am in good health and can participate in such activity. I understand I am engaging in this project and assume all risk and responsibility. In the event that I/the volunteer is injured and requires the attention of a doctor, I consent to any reasonable medical treatment as deemed necessary by a licensed physician.

In addition, the volunteer agrees to the following UNLESS it is initialed to opt out:

_____ I authorize the Baptist General Association of Virginia, its affiliates and partners, to copyright and publish all photographs and video in which I/my child may appear or speak in to publicize or promote future events and/or ministries of the organization. I release all claims against the Baptist General Association of Virginia with respect to the copyright, publication or use of such photographs or video footage, including any claim for compensation related to their use.

_____ is permitted to participate in activities sponsored by Virginia Baptist Disaster Response.
NAME OF VOLUNTEER

SIGNATURE [OF VOLUNTEER OR PARENT/GUARDIAN]

DATE



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Please keep this form AND insurance card on your person at all times.
We are grateful you can

VOLUNTEER MEDICAL FORM FOR

INSURANCE & PHYSICIAN INFORMATION

Medical Insurance Carrier: _____ Policy Number: _____

Primary Physician: _____
NAME PHONE

Dentist: _____
NAME PHONE

Other Physician: _____
NAME AND DESCRIPTION PHONE

MEDICAL HISTORY

If necessary, describe in detail the nature and severity of any physical and/or psychological ailment, illness, propensity, weakness, limitation, handicap, disability or condition to which the participant is subject and of which the staff/leaders should be aware. Please also include any action of protection required on account thereof.

Please check the following areas of concern for you/your child. If necessary, add another page with details.

- History of the following:
 Trick Knee Weak Ankles Bad Back Other (Describe: _____)
- Subject to:
 Diabetes Epilepsy Heart Disease Hypertension
- Does the participant have allergies to (please list if applicable):
 Pollens Medications Foods Insect Bites
 Details: _____
- Date of last Tetanus shot: _____
- Appendix Removed? _____
- Does the participant wear: Glasses Contacts
- Please list any current medications or medical concerns of which leaders or medical personnel should be aware.

8. Please list and explain any major illnesses the participant has experienced during the last year. Should the participant's activity be restricted for any reason? Please provide specifics.

