Jack County STOMP Volunteers

Liability/Medical Release Form

In consideration for me to be accepted as a STOMP volunteer I, hereby release, forever discharge and agree to hold harmless Jack County STOMP and the directors, from any and all liability. Liability includes: claims or demands for personal injury, sickness or death, as well as property damage and expenses, of any nature whatsoever which may be incurred by the undersigned that occurs while I am participating in a volunteer project. Furthermore, I hereby assume all risk of personal injury, sickness, death, damage and expense as a result of participation in any/all volunteer activities. Furthermore, authorization and permission is hereby given to Jack County STOMP to furnish any necessary transportation, food and lodging to this volunteer. The undersigned further agrees to hold harmless and indemnify Jack County STOMP, its directors, employees, volunteers and participating agents, from any liability sustained by said organization as the result of negligent, willful or intentional act of myself, as well as expenses incurred attendant thereto.

I understand that:

a. I will participate in all volunteer activities applicable to the project day(s) I sign up, and that
b. I release Jack County STOMP and/or any Partner Agencies to use photographs, video, audio and or ideas obtained from me during the volunteer project/event.

Volunteer Name: _____

Parent/Guardian Signature (if applicable): _____

I hereby grant permission for myself to participate fully in the volunteer project activities, evaluation and assessment of volunteer project experience including demographics/personal information. I hereby give permission to take me to a doctor or hospital and hereby authorize medical treatment, including but not limited to emergency surgery or medical treatment, and assume the responsibility for all medical bills. Further, should it be necessary for me to return home due to medical reasons, disciplinary action or otherwise, I hereby assume all transportation costs.

Do you have Medical Insurance? _____Yes _____No

IF YES, PLEASE ATTACH A COPY OF YOUR INSURANCE CARD.

Insurance Company: _____

Policy #: _____

Contact Info: _____

Physician Number: _____

I, the undersigned, understand the appropriate medical staff and/or an adult may administer any required medication to me if needed.

Do you take any daily medication? _____Yes _____No

If YES, please specify: _____

_____

_____

Do you have any allergies (food, medical, etc.)? _____ Yes _____ No

If YES, please specify: _____

_____

_____

In case of emergency, who should be notified? (Please provide two emergency contact persons; if under 18 make sure one is someone other than a Parent/Guardian):

Name: _____

Relationship: _____ Phone: _____

Name: _____

Relationship: _____ Phone: _____