

# Volunteer Medical Information and Emergency Contact Form

Please complete this form. The information provided will be kept confidential and used solely for emergency purposes during volunteer activities.

## 1. Volunteer Personal Information

Full Name:

Date of Birth (MM/DD/YYYY):

Phone Number:

Email Address:

Home Address:

## 2. Primary Emergency Contact

Contact Person Full Name:

Relationship to Volunteer:

Primary Phone Number:

Secondary Phone Number:

## 3. Secondary Emergency Contact

Contact Person Full Name:

Relationship to Volunteer:

Primary Phone Number:

## 4. Medical Information

Blood Type:

Known Medical Conditions / Illnesses:

Allergies (Food, Medication, Environmental):

Current Medications:

Primary Care Physician Name:

Physician Contact Number:

Health Insurance Provider:

Policy Number:

## 5. Authorization and Consent

In the event of an emergency, I authorize the organization to secure necessary medical treatment for me. I understand that every effort will be made to contact my emergency contacts listed above.

Volunteer Signature (Sign after printing):

Date (MM/DD/YYYY):