

CAPITAL REGION MEDICAL CENTER
VOLUNTEEN CONSENT FORM

GENERAL INFORMATION

Date _____
Name _____ Phone _____
Address _____
Date of birth (month/day/year) ____/____/____ M____ F____ (check one)

EMERGENCY CONTACTS

Person(s) to be notified in case of emergency
Name _____ Relationship _____
Phone _____
Name _____ Relationship _____
Phone _____

MEDICAL HISTORY

Name of personal physician _____ Phone _____
Is your teen under a doctor's care? _____ Why? _____
Is your teen on any medication? _____ What kind(s)? _____
Does your teen have any chronic (permanent) illnesses? _____

Any skin eruption present (rashes, severe acne, etc.)? _____
Any history of seizures? _____

Please indicate if your teen has had the following:
asthma/allergies (including medication) _____
history of chicken pox _____

IMPORTANT: Please provide the following vaccination dates:

Measles/mumps/rubella: 1st vaccination ____/____/____ 2nd vaccination ____/____/____
Date of most recent tuberculosis test ____/____/____

PERMISSION STATEMENT

I _____, parent/guardian of _____,
(please print) (please print)
hereby give permission for my son/daughter/ward to volunteer at Capital Region Medical Center and to be treated at Capital Region Medical Center in an emergency.

Signature of Parent or Guardian