



REGISTRATION AND MEDICAL RELEASE FORM 2007

Group Name: _____ Group #: _____
City: _____ State: _____ Your Center: _____

Please note:

- (1) Keep notarized form in your vehicle at all times!!
(2) Attach a copy of your medical insurance card to this form.
(3) Give a copy of this form to the Center Staff upon your arrival.

REGISTRATION INFORMATION:

Participated with ASP before? (circle) Yes No
Last Name _____
First Name _____ MI _____
Nickname _____
Address _____
City, State, Zip _____
Phone _____
Marital Status (circle 1) single married widowed divorced
Birthday _____ (mon/day/year)
Gender (circle) Male Female
Occupation _____
Email address _____

EMERGENCY MEDICAL INFORMATION:

Medical information on this form will only be used if medical treatment is needed. It will be used for no other purpose.

Social Security # _____ (optional) Date of last Tetanus shot _____

Medication(s) you are currently take (prescribed & over-the-counter - please list all - this is extremely important!!)

Medication(s) you CANNOT take _____

Any allergies &/or special health problems or concerns _____

Medical insurance information:

Company name _____ Phone _____
Address _____ City, State, Zip _____
Policy # _____
Policy Holder's ID # _____
Relationship to policyholder _____

In an emergency, please contact:

Name _____ Relationship _____ Address _____ City, State, Zip _____ Day Phone _____ Evening Phone _____ Cell Phone _____ Also on ASP? (circle) Yes No

Physician information:

Physician name _____ Phone _____

MEDICAL RELEASE:

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

Further, 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 Appalachia Service Project, Inc. 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.

Volunteers aged 18 years or older:

Volunteers under 18 years of age:

Signature

Date

Signature

Date

Parent/Legal Guardian Signature

Date

Relationship: (circle) Parent or Guardian

Notarization required for all ASP volunteers!!

_____,
Name of participant (18 years & older) OR name of parent/guardian of minor participant

appeared before me _____, a Notary Public of _____
(Notary's name) (County)

County in the State of _____, the person whose signature appears above
(State)

and with whom I am personally acquainted and acknowledge that he/she executed the within
instrument for the purposes therein contained.

Witness my hand and official seal this _____ day of _____, 200_____.

(Notary Public)

My commission expires: _____