AUTHORIZATION FOR MEDICAL TREATMENT,
RELEASE AND INDEMNITY AGREEMENT

I _____ , am participating in activities provided by i am VolunTourism LLC ("i am VolunTourism"), under the supervision of i am VolunTourism coordinators, staff, volunteers and/or other chaperoning adults (collectively, " i am VolunTourism Representatives"). I grant this authorization to i am VolunTourism Representatives so that I may participate in the activities and so that I may receive all appropriate medical attention while in the care of or under the control of or in the possession of, i am VolunTourism Representatives. I understand that i am VolunTourism Representatives will attempt to contact my family promptly should I require medical attention, but I specifically direct that they obtain such medical care for me as they, in their sole discretion, deem advisable.

I hereby grant my consent and authorization to i am VolunTourism Representatives to obtain such medical, dental, psychological and/or surgical treatment as they in their sole discretion shall deem necessary for the treatment of myself due to accident or illness.

I understand that i am VolunTourism is providing no medical insurance of any kind, and I agree that my insurance shall be Primary. I assume full responsibility for all bills and charges incurred in the treatment of myself, and I agree to reimburse and indemnify all expenses incurred on behalf of myself by i am VolunTourism, i am VolunTourism Representatives and any other agents, employees, sponsors, volunteers, etc.

_____ _____

Signature Print Name

STATE OF _____

COUNTY OF _____

Personally appeared before me, the undersigned authority in and for the said County and State, on this _____ day of _____, 20____ , within my jurisdiction, the within named _____, who acknowledged that _____ executed the above and foregoing instrument.

_____

NOTARY PUBLIC

My Commission Expires:

[AFFIX NOTARIAL SEAL]

MEDICAL INFORMATION

Name _____
Birth Date____/_____/_____ Age_____ Sex_____
Address_____
City_____State_____Zip_____
Employer_____
Spouse_____
Home phone (_____)_____ Work phone (_____)_____ Cell phone (_____)_____
Family Physician_____ Phone (_____)_____

Other person to contact in case of emergency:
Name_____
Home phone (_____)_____ Work phone (_____)_____Cell phone (_____)_____
Employer_____

HEALTH HISTORY

Check if you have had:

___ear infections	___dietary restrictions*	___chicken pox	___measles
___heart trouble*	___ asthma*	___diabetes	___other*

___operation or serious health problem*
* Explain in detail below:

Please explain or list existing medical conditions:

Check if allergic to:

_____bees/insect bites	____penicillin	____other drugs	_____foods

Please explain or list additional allergies below:

List medications you are currently taking, including, vitamins. (Prescription medicines MUST have pharmacy label and name of doctor.)
Medications:

Date of last tetanus booster: _____ (If you don't know the date but you know this booster is up-to-date, please write "current". If this booster is not up-to-date please seek the advice of your physician.)

This history is correct as far as I know. I am able to engage in all activities except (list prohibited activities):

Please provide information concerning any insurance benefits for which you are eligible.
Insurance carrier_____Phone_____

Address_____

Policy #_____

Group #_____