



Volunteer Medical Emergency Form

Name _____

Address _____

Date of Birth _____ **Phone** _____ **(H)** _____ **(W)** _____

Email _____ **Fax** _____

Emergency Contact:

Name _____

Relationship _____

Phone (day) _____ **(evening)** _____

Family Doctor

Name _____

Phone _____ **Hospital Preference** _____

Physical conditions to be noted (such as allergies to bee stings, present medications, etc.)

I, _____ (name) acknowledge that Meals of Marin provides no medical coverage for any accident or injury resulting from my participation in the Meals of Marin programs. I understand that any child under the age of 13 must be accompanied by an adult while on Meals of Marin facilities.

Signed _____ Dated _____