VOLUNTEER TRAINING MEDICAL RELEASE

Marin Chapter

Please Print

AMIGOS Volunteer Name:____
First M.I. Last Preferred Name

Address:____
Street Apt. Number

____
City State Zip Code

Father:__________________________________ **Mother**:__________________________________

Address:_________________________________ **Address**:_________________________________

____ ____

Home Phone: (   )________________________ **Home Phone**: (   )________________________

Cell Phone: (   )________________________ **Cell Phone:** (   )________________________

Email: __________________________________ **Email:** __________________________________

Please describe briefly any current health issues (including allergies) that may affect the above Volunteer's participation in AMIGOS training activities:

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MEDICAL RELEASE

As the parent / legal guardian of ______________________________, I hereby grant permission for a representative of Amigos de las Américas Marin Chapter training program to seek and obtain medical treatment for my son / daughter if deemed necessary per AMIGOS training staff during a training event.

Date: _________________ Volunteer: ____

Date: _________________ Parent / Legal Guardian:____

Date: _________________ Parent / Legal Guardian:____