Volunteer Liability Release Form

I would like to volunteer for the Broome County Council of Churches Inc. I understand that I am responsible for my own medical insurance and will not hold Broome County Council of Churches Inc. liable for any injury or damage to myself, or my property, while volunteering at the Broome County Council of Churches.

TITLE | PRINTED NAME OF VOLUNTEER | EMAIL ADDRESS | PHONE NUMBER

ADDRESS | CITY, STATE, ZIP

DATE OF BIRTH | LAST 4 DIGITS OF SS# | PROGRAM (CHOW, FIAV, JAIL, HOSPITAL...) | GROUP AFFILIATION (if any)

TODAYS DATE | VOLUNTEER'S SIGNATURE

MAY WE USE/TAKE PHOTOGRAPHS AND/OR VIDEO THAT WE MAY HAVE OF YOU WHILE YOU WERE VOLUNTEERING FOR THE BROOME COUNTY COUNCIL OF CHURCHES FOR PROMOTIONAL PURPOSES? (CIRCLE ONE) YES / NO

EMERGENCY CONTACT INFORMATION

ANY KNOWN ALLERGIES | EMERGENCY CONTACT NAME | PHONE NUMBERS

ADDRESS | CITY, STATE, ZIP

PARENTAL CONSENT (If participant is under the age of 18)

I give permission for my child to serve as a volunteer for the Broome County Council of Churches. In the event my child requires any medical care while serving with the Council, and I am unavailable,

(PARENT/GUARDIAN WHO IS AUTHORIZED TO CONSENT TO MEDICAL CARE OF THIS MINOR),

authorizes any doctor or hospital to provide such treatment as that individual determines would be appropriate to care for the condition with which the minor presents to said doctor or hospital. The Broome County Council of Churches shall not be liable for any health care, which its representative authorizes, as long as such care is recommended by the hospital or the doctor.

I understand that I am responsible for this minor's own medical insurance and will not hold the Broome County Council of Churches Inc., or any of its agents, liable for any injury or damage to this minor while volunteering for the Council.

PRINTED NAME OF PARENT/GUARDIAN | RELATIONSHIP TO MINOR | PHONE NUMBERS

ADDRESS | CITY, STATE, ZIP

INSURANCE COMPANY | POLICY NUMBER

DOES THIS MINOR HAVE ANY PHYSICAL LIMITATION THAT WE NEED TO BE AWARE OF? (USE REVERSE SIDE IF NEEDED)

PLEASE LIST ABOVE ANY ALLERGIES OR MEDICATIONS YOUR CHILD HAS (USE REVERSE SIDE IF NEEDED)

I GIVE PERMISSION FOR ABOVE NAMED MINOR TO USE POWER DRILLS: (CIRCLE ONE) YES NO

DATE | PARENT/GUARDIAN SIGNATURE