TEXAS DISTRICT LUTHERAN CHURCH – MISSOURI SYNOD
DISASTER RELIEF VOLUNTEER REGISTRATOIN AND RELEASE

PERSONAL INFORMATION:

Name:_____ Age _____
Address:_____
Phone: (_____)_____ Email:_____
Home Church::_____
Special Skills:_____
_____
_____

MEDICAL INFORMATION:

Indicate any medical information that would be needed in the event of illness or injury including but not limited to allergies, medical condition, or medications._____
_____

IN CASE OF EMERGENCY CONTACT:

Name_____Relationship_____
Contact Information_____
Physician Name_____ Phone:_____
Insurance Company_____
_____

NOTICE:

Disaster relief efforts pose certain hazards, including unforeseen dangers, inherent to the type of work that may be involved and the conditions which may be faced. Consider these risks before accepting any particular assignments. These risks can be increased based upon the general health of the volunteer and you may wish to consult with your family physician. Please be aware that volunteers are not covered by the workmen's compensation or other medical insurance of the Texas District of the Lutheran Church – Missouri Synod or any related or affiliated organizations and volunteers will need to rely on their own insurance. Volunteers participate in the relief efforts with knowledge of the risk and acceptance of responsibility for any injury or illness._____

RELEASE

I hereby agree to release and hold harmless the Texas District of the Lutheran Church – Missouri Synod, its directors, officers, employees, independent contractors, agents and volunteers for death, injury or property damage arising out of or relating to my volunteer efforts, except to the extent prohibited by law. This waiver and release is executed by me voluntarily and I acknowledge that I have been advised and have had the opportunity to seek legal counsel if I have any questions concerning this release. I certify that the above information is correct and consider myself able to participate. In an emergency and if I am unable to respond, I give my consent to perform immediate treatment, employ health care professional, transfer me to a health care facility, order diagnostics or perform surgery as deemed necessary; provided that reasonable efforts will be made to reach any emergency contact as listed above.

Volunteer Signature: _____
Printed Name: _____

If Volunteer is under age 18 a parent or legal guardian must also sign.
Signature of Parent or Legal Guardian:_____
Printed Name _____
Relationship to Volunteer_____