Release for Medical Emergency Care
Honduras Mission
Central American Relief Effort

To whom it may concern:
I hereby give my consent to any emergency facility and physicians to administer necessary treatment to my child/self, _____ in the event of an emergency. I give consent to transport by ambulance if the situation warrants it. In addition, I agree to be financially responsible for any medical expenses that are incurred by my child/self.

_____ _____
Family Physician's Name **Phone Number**

Allergies: _____

Date of last DPT or Tetanus shot: _____

Are there any other medical or emotional considerations that we should be aware of:
_____
_____

Health Insurance Company: _____
Policy No. : _____ Expiration date; _____

Gender _____ Date of Birth _____
SS No./Passport no._____
Beneficiary for Insured _____ Relationship _____
Home Country _____
Mailing Address _____
Telephone _____ Fax _____ Email _____

_____ _____

Signature of Parent, Guardian or Participant **Date**