



LOUISIANA UNITED METHODIST DISASTER RECOVERY MINISTRY

141 North 6th Street, Baton Rouge, LA. 70802 225-346-5193 fax 225-346-6974 www.laumcstormrelief.com

PARTICIPANT LIABILITY AND MEDICAL RELEASE FORM

Please read before signing as this constitutes the agreement and the understanding of your working relationship as a volunteer with The Louisiana United Methodist Disaster Recovery Ministry.

- **I, _____** acknowledge and state the following:
- **I have chosen** to travel to perform clean-up/construction work designed to repair disaster damage.
- **I understand** that this work entails a risk of physical injury and often involves hard physical labor, heavy lifting and other strenuous activity; and that some activities may take place on ladders and building framing other than ground level.
- **I certify** that I am in good health and physically able to perform this type of work.
- **I understand** that I am engaging in this project at my own risk. I understand that this is a "grass roots" activity to support individuals adversely affected by hurricane/flood disaster, or receiving assistance to repair or replace substandard housing.
- **I assume** all risk and responsibility for any damage or injury to my property, or any personal injury and related medical costs and expenses which I may sustain while involved in this project.
- In the event that my supervising disaster organization arranges accommodations, I understand that they are neither responsible nor liable for my personal effects and property, and that they will not provide lock up or security for any items.
- **I will hold them harmless** in the event of theft, or loss resulting from any source or cause.
- **I further understand** that I am to abide by whatever rules and regulations may be in effect for the accommodations at that time.
- **By my signature**, for myself, my estate and my heirs, I release, discharge, indemnify and forever hold harmless *The Louisiana United Methodist Disaster Recovery Ministry*, together with its officers, agents, servants and employees, from any and all causes of action arising from my participation in this project, and travel, or lodging associated therewith, including any damages which may be caused by their negligence.

Signature _____ Date _____

Medical Information

I have accidental insurance coverage: Yes ___ No ___

I elect to buy GBGM accidental insurance coverage: Yes ___ No ___

My health insurance company is: _____

Policy Number: _____

Medical History: _____ **Date of Birth:** _____

Medications: _____

(Circle or check below)

Allergies _____ Epilepsy _____ Blood Type: _____

Diabetes _____ Heart Condition _____

Physical limitations or concerns: _____

Signature: _____ **Date** _____

Street address _____ City _____ State ___ Zip _____

Emergency Contact Name & Phone _____

Church or Organization Name _____

Witness _____