# Volunteer Medical Information, Treatment Authorization, and Release Form

Esperanza International & Fundación Esperanza de Mexico

**Name:** _____ **Date of Birth:** _____ **Country:** _____

**Address:** _____ **City:** _____ **State:** _____ **Zip:** _____

**Emergency Contact Name:** _____ **Relationship:** _____

**Phone 1:** _____ **Phone 2:** _____

**Volunteer Pertinent Health History:**

**Medical conditions:** such as asthma, diabetes etc. and any information needed in the event you are unable to answer questions.

**Current Medications:**

**Date of Last Tetanus Shot:** ***(MUST have had shot in the last ten years before participating)*** _____

**Allergies:**

Have you ever had a systemic allergic reaction to bee stings, food, medicine etc.? ❑ Yes ❑ No

If yes, what was the precipitating substance and what was the treatment?:

Esperanza works in the greater Tijuana region of Mexico. Emergency treatment will be provided through available Doctors, Clinics and Hospitals in Mexico when necessary. Please remember that caution, careful planning and prevention on your part will greatly reduce the need for emergency medical treatment. Bring your medications, EpiPen, inhalers or other needed treatments with you.

**VERY IMPORTANT INFORMATION – PLEASE READ AND ACT –**

**Esperanza requires all volunteer participants to have international medical insurance during their volunteer experience with Esperanza in Mexico.** Not all insurance providers include out of country coverage. Please contact your insurance provider in advance of your event to learn about your out of country coverage & procedures for treatment. If you don't have out of country coverage, inexpensive travel insurance is available online. More information on what we require, please visit our website at: https://esperanzaint.org/insurance/

**Health Insurance Information:**

**Insurance Provider:** _____ **Member Number:** _____

**Doctor's Name:** _____ **Doctor's Phone:** _____ – _____ – _____

**I hereby authorize** the leader(s) of the group I am participating with or any representative, agent or staff of Esperanza to consent to medical or dental treatment on my behalf including but not limited to any X-ray examination, anesthetic, medical/dental or surgical diagnosis or treatment, and hospital care to be performed by a licensed physician, surgeon, medical clinic, or hospital in Mexico or the United States.

**I also hereby authorize** the leader(s) of the group that I am participating with or any representative, agent or staff of Esperanza to have access to my medical records, and to disclose the contents to others as they deem necessary.

**I hereby release** and forever discharge and hold harmless Esperanza and its successors and assigns from any and all liability, claims, and demands of whatever kind of nature, either in law or in equity, which arise or may hereafter arise on account of any first aid, medical/dental treatment, or service rendered, or with the decision by any representative or agent of Esperanza to exercise the power to consent to medical or dental treatment and disclosure of information.

**I understand that**, as the volunteer or parent/legal guardian, I will be responsible for the cost of any service or treatment.

| Date | Signature of Volunteer | Print Name |
|---|---|---|
| Date | *Signature of Parent/ Legal Guardian if Volunteer is a Minor* | Print Name |

Form Revised Mar 27, 2023