

**TEXAS DISTRICT and SOUTH WISCONSIN DISTRICT
LUTHERAN CHURCH – MISSOURI SYNOD
DISASTER RELIEF VOLUNTEER REGISTRATOIN AND RELEASE**

PERSONAL INFORMATION:

Name: _____ Age _____
Address: _____
Phone: (____) _____ E-mail _____
Birthdate: _____ Gender: ____ Home Church: _____
Medication(s): _____

Known Allergies: _____

MEDICAL INFORMATION:

Known medical conditions

IN CASE OF EMERGENCY CONTACT:

Name _____ Relationship _____
Contact Information _____
Physician Name _____ Phone: _____
Insurance Company _____

NOTICE:

Hurricane 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 or the South Wisconsin 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 and the South Wisconsin District of the Lutheran Church ó 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: _____