

**Project Chacocente, USA**  
**Volunteer Medical Release Form**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Allergies: \_\_\_\_\_

Current Medications: \_\_\_\_\_

Ongoing Medical Conditions: \_\_\_\_\_

Participant's Health Care Provider and Telephone: \_\_\_\_\_

Emergency Contact Name and Telephone: \_\_\_\_\_

Medical Insurance Provider: \_\_\_\_\_

Policy Number: \_\_\_\_\_

By signing below the volunteer hereby declares all information in this document to be correct, authorizes the sharing of this information with any local health care providers involved in the volunteer's medical care, and confirms understanding that any medical expenses the volunteer incurs in Nicaragua or upon return to the US are the sole responsibility of the volunteer.

Volunteer's Signature: \_\_\_\_\_

Date \_\_\_\_\_

**Notarization of Medical Release Form**

STATE OF \_\_\_\_\_

PARISH OR COUNTY OF \_\_\_\_\_

On this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ (*year*), before me personally appeared \_\_\_\_\_ to me known to be the same person described in and who executed the within instrument, and who acknowledged the same to be the free act and deed thereof.

Notary Public \_\_\_\_\_ My Commission Expires \_\_\_\_\_

County/Parish \_\_\_\_\_

State of \_\_\_\_\_