Collegiate Challenge

Emergency Contact Information

Volunteer Mobilization department

Team Leaders: KEEP THIS FORM WITH YOU AT ALL TIMES! Do NOT return it to the Collegiate Challenge office!

Collegiate Challenge Participant: Thoroughly complete this form and return it to your team leader.

1 PARTICIPANT INFORMATION

Full name ______________________________

Allergies (medicine, food, etc.) ______________________________

Any special dietary needs ______________________________

List any medication being taken ______________________________

Date of last tetanus shot ______________________________

Physical impairments ______________________________

Other ______________________________

Family physician ______________________________

Address ______________________________

City ______________ State ______________ Zip/Postal code ______________

Phone ( ) ______________________________

Name of insurance carrier ______________________________

Phone number of insurance carrier ( ) ______________ Policy number ______________

Social Security number of the policy member (i.e. parent) ______________________________

2 IN CASE OF EMERGENCY, CONTACT:

Name ______________________________ Relationship ______________________________

Address ______________________________

City ______________ State ______________ Zip/Postal code ______________

Daytime phone ( ) ______________ Evening phone ( ) ______________ Cell ( ) ______________

3 PARENTAL AUTHORIZATION FOR TREATMENT OF A MINOR CHILD

Note: The Campus Chapters and Youth Programs department of Habitat for Humanity International does not require completion of Parental Authorization for Treatment of a Minor Child, but the school faculty member/chaperone of the Collegiate Challenge trip can require the completion by participants under 18 years old.

I, ____, am the parent or legal guardian having custody of ________________________________, a minor child. As such parent or legal guardian, I hereby authorize and appoint ____________________________________, an adult in whose care the minor child has been entrusted as my agent to act for me with respect to my minor child, ______________________________, from this ________ day of ____________________, 20____ to the __________ day of _______________________, 20_____ and in my name in any way I could act in person to make any and all decisions for me with respect to my minor child, ______________________________, concerning my minor child's personal care, medical treatment, hospitalization and health care and to require, withhold or withdraw any type of medical treatment or procedure, including X-ray examination, anesthetic, medical or surgical diagnosis or treatment which may be rendered to my minor child under the general or special supervision and on the advice of any physician or surgeon licensed to practice in the state in which treatment is sought. My agent shall have the same access to my minor child's medical records that I have, including the right to disclose the contents to others.

Witness ____ Parent/Guardian ____

Witness ____ Parent/Guardian ____

This Parental Authorization for Treatment of a Minor Child sworn to and subscribed before me by ____ and ____, the parents or legal guardians of ____, a minor child, this __________ day of _______________________, 20_____.

Notary Public ____

My commission expires ____

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(229) 924-6935 or (800) HABITAT, Ext. 2215 fax (229) 410-7443
colchal@habitat.org www.habitatyouthprograms/colchal

PDF/VM/10-08