

FOCOS VOLUNTEER MEDICAL RELEASE FORM

A. Patient Information

Name: _____ Sex: M F
 Birthdate: _____ Age: _____ Tele: (H) _____
 Address: _____ (W) _____
 _____ Fax: _____
 Your Email _____

B. In case of emergency contact:

Name: _____ Address: _____
 Tele: _____ Fax: _____ Email: _____

C. Medical Information

If yes, explain in the shaded area:

Medical Illness:	Yes	No	Immunizations	Yes	No
HEENT			Hepatitis A		
Pulmonary			Meningococcal		
Cardiac			Yellow Fever		
GI			Typhoid Fever		
GU			PPD		
GYN			Malaria Tab		
Musculoskeletal			Professional Certification:		
Neuro			License Type:		
Diabetes			Date/Number:		
Seizures			Type/Expiration:		
Mental Illness					
Arthritis					
Other:					

D. Current Medication/s:

E. Previous Surgeries (pls. list month & year)

F. Allergies:

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G. Medical Insurance:

Company Name	
Address	
Policy Number	

H. Authorization for treatment and release of information:

I, the undersigned, represent that the above information is accurate. I hereby give my permission to the FOCOS organization to provide me with medical and/or surgical treatment. I fully understand that, although my confidentiality will be maintained, any information acquired in the course of my medical and/or surgical treatment may be used by FOCOS in support of its purpose.

Signed: _____
 Dated: _____