



PARTICIPANT LIABILITY AND MEDICAL RELEASE FORM

Please read before signing as this constitutes the agreement and the understanding of your working relationship as a volunteer with The Louisiana United Methodist Disaster Recovery Ministry.

- I, _____ acknowledge and state the following:
- I have chosen to travel to perform clean-up/construction work designed to repair disaster damage.
- I understand that this work entails a risk of physical injury and often involves hard physical labor, heavy lifting and other strenuous activity; and that some activities may take place on ladders and building framing other than ground level.
- I certify that I am in good health and physically able to perform this type of work.
- I understand that I am engaging in this project at my own risk. I understand that this is a "grass roots" activity to support individuals adversely affected by hurricane/flood disaster, or receiving assistance to repair or replace substandard housing.
- I assume all risk and responsibility for any damage or injury to my property, or any personal injury and related medical costs and expenses which I may sustain while involved in this project.
- In the event that my supervising disaster organization arranges accommodations, I understand that they are neither responsible nor liable for my personal effects and property, and that they will not provide lock up or security for any items.
- I will hold them harmless in the event of theft, or loss resulting from any source or cause.
- I further understand that I am to abide by whatever rules and regulations may be in effect for the accommodations at that time.
- By my signature, for myself, my estate and my heirs, I release, discharge, indemnify and forever hold harmless *The Louisiana United Methodist Disaster Recovery Ministry*, together with its officers, agents, servants and employees, from any and all causes of action arising from my participation in this project, and travel, or lodging associated therewith, including any damages which may be caused by their negligence.

Signature _____ Date _____

Arrival Date _____ Departure Date _____

Medical Information

I have accidental insurance coverage: Yes ___ No ___
I elect to buy GBGM accidental insurance coverage: Yes ___ No ___

My health insurance company is: _____
Policy Number: _____

Medical History: _____ Date of Birth: _____

Medications: _____

(Circle or check below)

Allergies _____ Epilepsy _____ Blood Type: _____

Diabetes _____ Heart Condition _____

Physical limitations or concerns: _____

Signature: _____ Date _____

Street address _____ City _____ State _____ Zip _____

Emergency Contact Name & Phone _____

Church or Organization Name _____

Witness _____

**Fill out and return with \$200 check made out to "Young Leaders Initiative" to:
17117 W. 9 Mile Rd., Suite 1545
Southfield, MI 48075**