

Gettysburg Area School District
EMERGENCY INFORMATION FOR VOLUNTEERS

Print Name: _____

Birth Date: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Work Phone: _____

Physician Preference: _____ Physician's Phone: _____

Special Health Problems/Allergies/Medications we should know about, i.e. bee stings, diabetes, etc.) _____

In the event that I need emergency treatment requiring ambulance service and/or medical care, you have my permission to seek help as listed above or nearest MD/DO or ambulance/hospital available. I will assume responsibility for fees incurred by such an emergency (via my medical insurance if applicable).

Signature: _____ Date: _____

Your signature indicates that
you agree to comply with all
District Volunteer Policies