ADULT AUTHORIZATION FOR MEDICAL TREATMENT AND RELEASE

Grand Assembly of Colorado, IORG

It is recommended Adult Volunteers complete this form each year.
Adult Volunteers are not required to complete the "Adult Medical Information" section of
THIS FORM MUST BE COMPLETED ANNUALLY

Adult Volunteer Information

Full Name: _____

Address: _____

Email: _____ Phone:(Home)_____(Cell) _____

In the event of an emergency, please contact:

Name	Phone No.	Relationship
Name	Phone No.	Relationship
Name	Phone No.	Relationship

Authorization for Medical Care

If the individuals identified herein as my emergency contacts are unavailable after all reasonable efforts have been taken to contact those individuals, I hereby authorize and direct the Supreme Officer for the Grand Assembly of Colorado, International Order of the Rainbow for Girls, or her designee, as an agent to authorize on my behalf, emergency medical or surgical treatment, including hospitalization, in the event I am unable to do so and which, in the opinion of any licensed physician, surgeon, or hospital, is reasonably required or necessary for my treatment or care. Any physician, surgeon, or hospital is authorized to rely upon any authorization for treatment signed by the above designated agent to the same extent as if executed by me personally.

I hereby release and hold harmless the Grand Assembly of Colorado, the Supreme Officer, all members and volunteers of Colorado Grand Assembly and the International Order of the Rainbow for Girls, all Assemblies of Colorado Grand Assembly, the Masonic Fraternity, and any sponsoring body or affiliates thereof from any and all responsibility, liability or fault which may arise as a result of any exercise of discretion with respect to the provision of travel and/or health care of the Participant which is authorized by this agreement.

Additionally, I agree I shall be fully and solely responsible for payment or reimbursement of any medical charges or expenses incurred on my behalf and further agree to indemnify and hold harmless those released herein from any claim, demand or action which may be initiated, by any 3rd party, individual, organization or entity, against aforementioned parties for the recovery of such medical expenses, including any legal fees or expenses incurred in defending against such claims. I further agree that I shall be responsible to submit any claim through my insurance company.

Adult Volunteer Medical Information:
(This section, while helpful, is optional. Please check all that apply; if box checked, please explain)

The following information is needed by any hospital or practitioner not having access to my medical history:

Known allergies

- ☐ Drug/Medication: _____
- ☐ Food: _____
- ☐ Insect Stings: _____
- ☐ Hay Fever: _____
- ☐ Other: _____

Chronic/recurring illnesses:

- ☐ Asthma:
- ☐ Diabetes:
- ☐ Seizures/Epilepsy:
- ☐ Heart Condition: _____
- ☐ Other: _____

Adult Volunteer has the following physical limitations?

Date of last Tetanus Shot: _____

Medications currently being taken: _____

Other pertinent information medical personnel should be aware of:

Family Physician and telephone: _____

Medical Insurance Information
Adult Volunteer has active medical insurance coverage with the following medical insurance carrier:

Carrier Name: _____ Telephone No: _____

Policy Holder's Name: _____

Group ID: _____ Policy #: _____

Signature: _____ Date: _____

An electronic copy or a photocopy of this release shall have the same effectiveness as the original