



VOLUNTEER TRAINING MEDICAL RELEASE

Santa Clara Valley Chapter

Please Print

AMIGOS Volunteer Name: _____
First M.I. Last Preferred Name

Address: _____
Street Apt. Number

_____ City State Zip Code

Father: _____

Mother: _____

Address: _____

Address: _____

Home Phone: () _____

Home Phone: () _____

Cell Phone: () _____

Cell Phone: () _____

Email: _____

Email: _____

Please describe briefly any current health issues (including allergies) that may affect the above Volunteer's participation in AMIGOS training activities:

MEDICAL RELEASE

As the parent / legal guardian of _____, I hereby grant permission for a representative of Amigos de las Américas Santa Clara Valley Chapter training program to seek and obtain medical treatment for my son / daughter if deemed necessary per AMIGOS training staff during a training event.

Date: _____ Volunteer: _____

Date: _____ Parent / Legal Guardian: _____

Date: _____ Parent / Legal Guardian: _____