

Hansen Volunteer
Adult Medical Release Form
University of California Cooperative Extension

This Medical Release Form is authorized for volunteer functions and activities for the dates specified below:

First Name	Last Name	Volunteer Position
County and State		Dates (From / To) to

While I am attending or traveling to or from this Hansen Agricultural Center function, I HEREBY AUTHORIZE THE ADULT HANSEN VOLUNTEER OR STAFF MEMBER, or in his/her absence or disability, any adult accompanying or assisting him/her, TO CONSENT TO THE FOLLOWING MEDICAL TREATMENT FOR ME SHOULD I BE UNABLE TO MAKE A DECISION:

Any x-ray examination, anesthetic, medical or surgical diagnosis or treatment, and hospital care which is deemed advisable by, and is to be rendered under the general or special supervision of any physician and/or surgeon licensed under the provisions of the Medical Practices Act, California Business and Professions Code Section 2000 et seq.; or any x-ray examination, anesthetic, dental or surgical diagnosis or treatment, and hospital care to be rendered by a dentist licensed under the provisions of the Dental Practices Act, California Business and Professions Code Section 1600 et seq.

This authorization is given pursuant to the provisions of Section 25.8 of the Civil Code of California. This authorization shall remain effective until I complete my activities in this program unless sooner revoked in writing. I understand that I will be responsible for the cost of any service or treatment provided not covered by the Volunteer Accident/Sickness Insurance Program sponsored by UC Cooperative Extension.

Authorization and Consent and Release

I hereby certify that I am in good health and can travel to and participate in all functions of the Hansen Volunteer as described above. I understand it is my responsibility to keep the information on this form updated (including Health History) by contacting the Volunteer Coordinator or UCCE Office.

Signature	Date
(_____) Emergency Day Phone (with area code)	(_____) Emergency Night Phone (with area code)

Mailing Address	City	State	Zip
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Non-Consent

I do not desire to sign this authorization and understand that this will prohibit me from receiving any non-life threatening medical attention in the event of an accident or illness.

Signature	Date
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University policy and the State of California Information Practices Act of 1977 require the following information be provided when collecting personal information from you: The information entered on this form is collected under authority of the Smith-Lever Act. Submission of the medical data is voluntary. However, a signature is required on one or the other of the two signature lines above. Failure to provide the medical information and authorization may result in our inability to provide necessary medical treatment. You have the right to review University records containing personal information about you, with certain exceptions as set forth in policy and statute. Copies of University policies pertaining to the collection, use, or release of personal data are available for your examination from the local UCCE County Director, 4-H Youth Development Advisor, CE Volunteer Coordinator, University of California, DANR Building, One Hopkins Road, Davis, CA 95616-8575, (530) 754-8518. Only your own records are open to your review.

Any known or foreseeable intergovernmental transfer that may be made of the information is as follows: None