# Personal and Medical Information Form for Volunteers

Volunteers are requested to provide the following information to the state disaster relief director and to give it to the unit director upon arrival at the disaster work location.

## PERSONAL INFORMATION DATE_____

NAME_____E-MAIL_____
ADDRESS_____
CITY_____ST_____ZIP_____
CONTACT PHONE_____TEXT Y/N
HOME PHONE_____WORK PHONE_____
AGE____ DOB___/___/___ OCCUPATION_____
MARITAL STATUS M S W (circle one) SPOUSE'S NAME_____
HOME CHURCH_____
CHURCH ADDRESS_____
CITY_____ST_____PHONE_____

## EMERGENCY CONTACTS (please list two people)

1. NAME_____RELATIONSHIP_____
ADDRESS_____ST_____ZIP_____
CELL PHONE_____HOME PHONE_____
WORK PHONE_____

2. NAME_____RELATIONSHIP_____
ADDRESS_____ST_____ZIP_____
CELL PHONE_____HOME PHONE_____
WORK PHONE_____

## HEALTH INFORMATION

PHYSICIAN'S NAME_____PHONE_____
HEALTH INS CO NAME_____
GROUP/POLICY#_____INSURANCE CO PHONE_____
MEDICATIONS_____
_____
ALLERGIES_____SYMPTOMS_____
ANTIDOTES_____