

**VOLUNTEER/COURT WORKER HEALTH LIABILITY DISCLAIMER**

I/WE the undersigned VOLUNTEER(S)/COURT WORKERS, hereby RELEASE, DISCHARGE and WAIVE any claims, actions, or suit of any character, name and description that I/WE may have against the D/FW HUMANE SOCIETY, or its officers, agents, or employees as a result of any injuries and death received or sustained by VOLUNTEER(S)/COURT WORKERS, as a result of any work done on the shelter property or off-site as an official representative of D/FW HUMANE SOCIETY.

The undersigned have read and fully understand this agreement, and have not been offered any additional consideration or enticement, nor have been coerced to execute same, and the undersigned execute this agreement fully for the purposes and considerations expressed herein.

NAME: \_\_\_\_\_ PHONE NUMBER: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

**PERSON TO CONTACT IN CASE OF AN EMERGENCY:**

(This should be a person who can give permission for medical treatment.)

NAME: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_

HOME PHONE NUMBER: \_\_\_\_\_ WORK PHONE: \_\_\_\_\_

PHYSICIAN'S NAME: \_\_\_\_\_

PHONE NUMBER: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

1. Do you have any chronic health problems for which you take medication on a regular basis? ( )No ( )Yes

If Yes, list medications: \_\_\_\_\_

2. Do you have any allergies? (Include medication allergies) ( )No ( )Yes

If Yes, list allergies: \_\_\_\_\_

3. When was you last tetanus toxoid booster? \_\_\_\_\_

Are you able to take tetanus toxoid? \_\_\_\_\_

4. Have you ever had vaccinations against rabies: ( )No ( )Yes

5. Are you under a physician's care for any other health-related problems? ( )No ( )Yes

If Yes, explain: \_\_\_\_\_

6. Have you ever had any back injuries, or problems with lifting heavy weights in the past? ( )No ( )Yes

If Yes, explain: \_\_\_\_\_

7. Are there any physical or mental limitations that would be aggravated or would limit you from performing any specific job? ( )No ( )Yes

If Yes, explain: \_\_\_\_\_

8. Are you pregnant? ( )No ( )Yes

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent's signature for minor: \_\_\_\_\_ Date: \_\_\_\_\_