

Have you taken the Adult VIRTUS class?    YES            NO

**ADULT VOLUNTEER INFORMATION AND MEDICAL CONSENT**

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Participant's Name: \_\_\_\_\_  
Birth Date: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: Male / Female  
Spouse's Name \_\_\_\_\_  
Home Address: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_  
Email Address(es): \_\_\_\_\_

**MEDICAL CONSENT AND PERMISSION TO TREAT ADULT**

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To the best of my knowledge, I am in good health.

In the event of an emergency, I give permission to be transported to a hospital for emergency treatment. I wish the following person to be advised prior to any further treatment by the hospital or doctor.

Name: \_\_\_\_\_  
Please PRINT  
Home Address: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

If you are unable to reach the above, please contact:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell: \_\_\_\_\_ Work: \_\_\_\_\_

Name of Doctor: \_\_\_\_\_ Phone Number: \_\_\_\_\_

I am taking the following medication(s):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have the following Allergies: \_\_\_\_\_

\_\_\_\_\_

I have the following limitations: \_\_\_\_\_

\_\_\_\_\_

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

For Office Use Only

\_\_\_\_\_

\_\_\_\_ Virtus Certificate    \_\_\_\_ Background Check    \_\_\_\_ Code of Conduct    \_\_\_\_ Appendix B    \_\_\_\_ CP

T-Shirt size:	Small	Medium	Large	XLarge	XXLarge
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