



# IDENTIFICATION & MEDICAL RELEASE

Houston Chapter

**Please Print**

**Amigos Volunteer Name:** \_\_\_\_\_  
First M.I. Last Prefer to be called

**Address:** \_\_\_\_\_  
Street Apt. Number

\_\_\_\_\_  
City State Zip Code

**Father:** \_\_\_\_\_

**Mother:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Home Phone:** (\_\_\_\_) \_\_\_\_\_

**Home Phone:** (\_\_\_\_) \_\_\_\_\_

**Cell Phone:** (\_\_\_\_) \_\_\_\_\_

**Cell Phone:** (\_\_\_\_) \_\_\_\_\_

**Current health issues (including allergies) that may affect participation in training activities :**

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

## MEDICAL RELEASE

☑ As the Parent / Legal Guardian, I hereby grant permission for a representative of the Houston Chapter of Amigos de las Americas to seek and obtain Medical treatment for my son / daughter if I cannot be reached in the event of an emergency.

☐ I do not grant permission for Medical Treatment.

Date: \_\_\_\_\_ Parent / Legal Guardian: \_\_\_\_\_