



CONSENT FOR MEDICAL INFORMATION

To be completed by the applicant and submitted to the Society.

Applicant's Name:		
--------------------------	--	--

*(Please **PRINT****LAST Name**.....**FIRST Name & INITIAL**)*

TO:	Physician Name & Clinic	
	Street	
	Town/City	
	Postal Code	

I hereby give my consent for you to provide the **CHILDREN'S AID SOCIETY OF NORTHUMBERLAND** with information as to my health and suitability as a volunteer driver or to work directly in other capacities with children or adults.

/ /	
Date (mm/dd/yyyy)	Signature of Applicant

Medical Reference

(to be completed by the Physician)

	/ /
Name of Volunteer (Please Print)	Birth Date (mm/dd/yyyy)

In your opinion, is he/she physically and emotionally fit to be a volunteer driver or to work directly in other capacities with children or adults? **Yes** **No**

To your knowledge is this patient currently under the care of any other physician or specialist? (i.e. psychiatrist, etc) **Yes** **No**

Further Comment:

	/ /
Signature of Physician	Date (mm/dd/yyyy)