

International Medical Release Form

Church Name:	City/State:			
PERSONAL INFORMA	TION			
Name:				
	je: Gender (M/F):			
Address:				
City:	State:	Zip:		
EMERGENCY CONTAC	стѕ			
1. Name:	Relationship:	Email:		
Home Phone: ()	Cell Phone: ()	Work Phone: ()		
2. Name:	Relationship:	Email:		
Home Phone: ()	Cell Phone: ()	Work Phone: ()		
HEALTH INSURANCE INFORMATION Medical Insurance Co.:				
Company's address:				
City:	State:	Zip:		
Family Physician's Name:		Phone:()		
		n required/recommended travel siting. Please check with your physiciar	n and	
(Initial) I hav immunizations.	re consulted my physician regard	ding this travel and am up to date on all	l	

MEDICAL INFORMATION

Depending on your trip desination, it's possible that your trip might include travel into the poorest parts of developing countries.

Conditions are frequently uncomfortable and physically challenging and can include:

- extended periods of walking on rough/unpaved paths
- demanding climbs often at high elevation

order to get clearance to participate in this trip.

- long travel times requiring use of modern and primitive, private and public transportation services
- transportation services that may lack accommodations for people with physical limitations
- dietary and climate changes that can add to the physical intensity of the trip
- Long periods of travel that may cause participants to experience lack of sleep is customary.
- Some areas may be remote and medical care may not be immediately available.

Please consider these factors as you prepare to serve in such areas.

If you have any medical conditions that may be difficult or challenging under the conditions described above, however minor, please complete the **Doctor's Release Form** and turn it in to your group leader in

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(Initial) I have cons	sulted my local physician and have attach	ned a Doctor's Release.
- or -		
	nd the medical risks outlined above. I do ne trip and am not receiving a medical rel	,
-	to be aware of any medical conditions or a required to share information with us.)	allergies, please feel free to

EMERGENCY AUTHORIZATION

In the event of an emergency, I hereby give permission to the medical personnel selected by my group leader or other designated adult leaders on my trip to order routine treatment for myself/my child. In the event of an emergency and neither the secondary contact or myself can be reached, I hereby give permission to the physician to hospitalize and secure proper treatment for myself/my child as named above.

I further authorize the release of the above medical information to appropriate medical personnel and/or the health coverage insurance company.

The health information above is correct, so far as I know, and the person herein described has permission to engage in all prescribed activities except as noted. Signature of Participant* Date Signature of Parent/Guardian* *Participants under 18 years old must have a parent/guardian signature. **NOTARY INFORMATION** The following to be completed by the notary witnessing parent/guardian and/or participant's signature. _____ the County of ______. Before me, a Notary Public, on this day personally appeared) to be the to me (or proved to me on the oath of person whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purpose and consideration therein expressed. Given under my hand and the seal of the office this day of . A.D. . Notary Public, Signature My commission expires the _____ day of _____, A.D._ .