Travel Release Form

Health Insurance

IMPORTANT INFORMATION:
A copy of the insurance card must be provided.

CONSENT FOR MEDICAL TREATMENT
Birthday:_______/_______/______________
Participant's Name: ___________________________________, wishes to be involved in the Faith Youth Group Missions trip to the Dominican Republic which will take place June 15-22, 2019. I understand certain circumstances may occur resulting in my child's need for medical/dental care and treatment, resulting in my inability to personally give consent for such care and treatment. I (parent/guardian if participant under 18), ___________________________ _____________________________, being of legal age, authorize Brian Graham, or any designated adult sponsor on the trip, or medical facility to act on my child's behalf should I be unable to do so and to consent to all medical/dental care and treatment, including but not limited to diagnostic test, x-ray examination, anesthesia, surgery or other procedures which the adult leaders deem necessary for my child's medical well-being for the duration of the trip. This consent is given in advance of any specific diagnostic tests, treatments and/or care in my child's behalf. Any consent by Brian Graham or any designated adult sponsor shall have the same force and effect as if I had personally given the consent.

Policy Holder's Name: __________________________________ Policy Number: _______________________________

Insurance Company: ___________________________________ Company Phone #: (____)_______-______________

Name (Mother/Guardian): _______________________________ Home Phone #: (_______)_______-_______

Address: ____ Cell Phone #: (_______)_______-______________

City: _________________________ State: ___ Zip: __________ Other Phone #: (_______)_______-______________

Name (Father/Guardian): _______________________________ Home Phone #: (_______)_______-______________

Address: ____ Cell Phone #: (_______)_______-______________

City: _________________________ State: ___ Zip: _________ Other Phone #: (_______)_______-______________

In Case of Emergency where parents cannot be reached, contact:

Name: ____ Home Phone #: (_______)_______-_______

Address: ____ Office Phone #: (_______)_______-______________

City: _________________________ State: ___ Zip: _________ Other Phone #: (_______)_______-______________

Medical Information

IMPORTANT INFORMATION:
We cannot use information and/or documents from previous mission trips because this form is used specifically for each mission trip and is not reusable. We use this information for the participant's health and safety. You must answer every question on the "Medical Checklist." Any misrepresentations will void participation.

MEDICAL CHECKLIST:
Please Indicate by Circling *yes* or *no* if the patient has:

Yes	**No**	Asthma or Chronic Wheezing	**Yes**	**No**	Kidney Problems
Yes	**No**	Mental Health Counseling treatment	**Yes**	**No**	High or Low Metabolism
Yes	**No**	Any other Respiratory Problems	**Yes**	**No**	Tuberculosis
Yes	**No**	Fainting Spells	**Yes**	**No**	Gall Bladder Stones or Colic
Yes	**No**	Cysts or Tumors of any kind	**Yes**	**No**	Rheumatism, Arthritis, Painful joints
Yes	**No**	Convulsions, Epilepsy, or Seizures	**Yes**	**No**	Prostrate Problems
Yes	**No**	Chronic or Persistent Cough	**Yes**	**No**	Severe Knee Problems
Yes	**No**	Parkinson's Disease	**Yes**	**No**	Venereal Disease
Yes	**No**	Anemia, any other Blood Disorder	**Yes**	**No**	Persistent, Recurring Indigestion,
Yes	**No**	Goiter	**Yes**	**No**	Stomach or Duodenal Ulcers
Yes	**No**	Serious Bodily Injury	**Yes**	**No**	Cancer
Yes	**No**	Diabetes or Hypoglycemia (low blood sugar)	**Yes**	**No**	Breast or Menstrual Disorder
Yes	**No**	Thyroid Ailment Issues	**Yes**	**No**	High Blood Pressure/any cardiac
Yes	**No**	Circulatory Trouble	**Yes**	**No**	Intestinal or Bowel Problems
Yes	**No**	Severe Allergic Reactions	**Yes**	**No**	Any Disease or Disability not Listed
Yes	**No**	Hearing or Vision Impairment		Please List: ____________________________	
Yes	**No**	AIDS virus or HIV		____________________________	

If you indicated 'Yes' on any question on this Medical Checklist, take this form to your physician so that they may fill out the following section. If you checked 'No' to all the questions on the Medical Checklist, proceed to 'Immunizations.'

Doctor's Release Section

(To be completed by your physician if you answered Yes to any of the questions above)

This person is planning on participating on a Faith Church Youth Group Missions Trip to the Dominican Republic this summer. They will be involved in a Kids Camp targeting ages 8-12. Activities may include running, swimming, and extended periods of walking and hiking as part of the daily itinerary. Dietary and climate changes add to the physical intensity of our trips as well as the high probability of, at some point, losing lack of sleep. Please be considerate of these factors as you fill out the following form.

Doctor's Name: ____
Address:______________________________________ City: __________________ State: ____ Zip: ________
Work Phone #: ____
Blood Pressure: ______________________ (Optional) Age:___________ Birthday: _____/______/______

I have reviewed this patient's Medical History and have performed a physical exam.
(Please check the appropriate choice):

______ I find him/her to be in adequate condition for international travel, participating in highly intense activities in a third world setting.

_______ I have prescribed a medical plan of action for him/her to meet prior to the mission trip in order to participate in the daily itinerary during the mission trip.

_______ I do not recommend this person to participate at this time.

Physician's Signature: ____ Date: ______/______/______

Immunizations (to be completed by Guardian if under 18)

TYPE	CIRCLE		DATE ADMINISTERED
Mumps/Measles/Rubella	**Yes**	**No**	____________________
Tetanus	**Yes**	**No**	____________________
Diphtheria/Pertussis	**Yes**	**No**	____________________
Polio	**Yes**	**No**	____________________
Varicella (chicken pox)	**Yes**	**No**	____________________
Typhoid	**Yes**	**No**	____________________
Flu shot	**Yes**	**No**	____________________
Typhoid	**Yes**	**No**	____________________
Hepatitis A	**Yes**	**No**	____________________

I, ______________________________, agree that it will be my sole responsibility to obtain information on travel immunizations that are required and/or recommended and travel precautions for the region of mission in which I am participating. I realize that immunizations must be completed 6 weeks prior to travel.

PLEASE COMPLETE THE FOLLOWING QUESTIONS BY CIRCLING THE APPROPRIATE RESPONSE:

Are you currently taking any prescribed medications? **Yes** **No**
If Yes, please specify the medication and the dosage: ____

Are you currently using any non-prescription drugs on a regular basis? **Yes** **No**
If Yes, please specify: ____
Will you take these on your trip? **Yes** **No**

Are you allergic to any medications/foods? **Yes** **No**
If Yes, please specify: ____

Have you ever received treatment/counseling for alcohol or chemical abuse? **Yes** **No**
If Yes, please specify when and where: ____

Are you presently under a physician's care for any illness? **Yes** **No**
If Yes, please explain: ____

What was the date of your most recent physical examination and who was the Physician? ______/______/______

Name of Doctor: ______________________________ Clinic/Hospital: ______________________________

What are your limitations based on health requirements (not preference)? ______________________________

PLEASE LIST ALL SURGICAL OPERATIONS OR HOSPITALIZATIONS THE PARTICIPANT HAS UNDERGONE:

Operations/Illness: ____

Reason: ____ Date: ______/______/______

Name of Hospital: ______________________________ Address: ______________________________

Name of Physician: ______________________________ City: __________ State: _____ Zip: ____

Remaining Effects: ____
(If more than one, please attach a separate piece of paper).

Please provide any details pertaining to your health not covered on this Travel Release Form. (Attach more paper if necessary)

Authorization

MEDICAL AND TRAVEL RELEASE (If you are under 18, a parent/guardian must complete the following)

On behalf of myself/my child, I further authorize Faith Church to:

Assign for the providing of medical treatment to my child or to members of the missionary group
Release any and all other medical information or records to any party deemed necessary by Faith Church representatives.
I hereby release Faith Church, and its servants, and employees for any and all damages, liability or costs resulting from the authorizing of medical treatment on my/my child's behalf under the terms of this consent.
I further hold Faith Church harmless from any and all costs, damages, or expenses incurred by Faith Church as a result of any claim or action filed by any party alleging damages incurred as a result of any medical treatment provided or authorization for treatment provided. I understand that this release and indemnification releases treatment for the conduct of Faith Church and its servants, and employees even if such conduct is negligent.
I am aware that serious illness or injury may occur on a mission trip and that such illness and injury may result in myself/my child incurring costs, expenses, and damages for which I am solely responsible including, but not limited to, return of myself/my child by air ambulance or other extraordinary means.
I hereby release and hold harmless Faith Church, its officers, employees, and representatives/volunteers from all liability for personal injury, including death, as well as all property damage or loss arising out of my/my child's participation on this trip.

BEHAVIORAL AGREEMENT
By participating with Faith Church Youth Group on this missions trip, I understand that I am expected to follow the stated rules as well as carry myself according to Christian principles.

SIGNATURES
My enclosed signature signifies my approval of all limitations listed above. I have read and understood the above information. My signature represents that all information on these forms is correct to the best of my knowledge.

________________________________ _______/______/______
Father's Signature (applicants under 18) Date

________________________________ _______/______/______
Mother's signature (applicants under 18) Date

____________________________ _______/______/______
Participant's Signature Date

A copy of the insurance card must be provided.