



**Medical Release / Permission to Treat Form**

**Team Information**

Team Leader: \_\_\_\_\_  
Trip Location: \_\_\_\_\_ Trip Dates: \_\_\_\_\_

**Personal Information**

Full Name: \_\_\_\_\_ Gender: \_\_\_\_\_  
SSN: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Parent/Guardian (if younger than 19 years old): \_\_\_\_\_

**Emergency Contact Information**

*Please provide the name and contact information of two individuals not traveling with your team who may be contacted in the event of an emergency.*

Name: \_\_\_\_\_  
Relationship to You: \_\_\_\_\_  
Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_  
Name: \_\_\_\_\_  
Relationship to You: \_\_\_\_\_  
Phone: \_\_\_\_\_ Alt. Phone: \_\_\_\_\_

**Insurance Information**

*Please attach a copy of the front and back of your insurance card.*

Insurance Company: \_\_\_\_\_  
Policy Holder: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Policy #: \_\_\_\_\_ Group #: \_\_\_\_\_  
Ins. Co. Address: \_\_\_\_\_ Phone: \_\_\_\_\_

**Medical Information**

Primary Care Physician: \_\_\_\_\_  
Physician Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Do you have any allergies? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, please explain: \_\_\_\_\_

List any specific medical conditions requiring medical treatment and/or medication: \_\_\_\_\_

List ALL medication taken on a regular basis: \_\_\_\_\_

List all operations/serious injuries (include dates) within the past five years:

Have you had contact with contagious or infectious diseases within the last four weeks? \_\_\_\_\_ yes \_\_\_\_\_ no  
If yes, please explain: \_\_\_\_\_

Do you have any special dietary restrictions? \_\_\_\_\_ yes \_\_\_\_\_ no  
If yes, please explain: \_\_\_\_\_

What type of pain medication may be given if necessary? \_\_\_\_\_

**Emergency Authorization**

I hereby give permission to medical personnel selected by my team leader or his/her designee (hereafter the Authorized Agent) to order X-rays, routine tests, and treatment for me. In the event of an emergency and neither my primary nor secondary contact can be reached, I hereby give permission to the physician selected by the Authorized Agent to secure proper treatment, hospitalize, order injections and/or anesthesia, and/or authorize surgery for me. I further authorize the release of the above medical information to appropriate medical personnel and/or the health coverage insurance company. In addition, I have, and do hereby, release White's Ferry Road Church of Christ, its employees or agents, and in country contacts from liability associated with participation in a mission trip. I understand that if I do not have medical insurance, I will be responsible for any medical expenses in the event of a sickness or injury.

I understand that there are risks involved in participating in a mission trip.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Must be signed by a parent or guardian if under 19 years of age.)

**The following is to be completed by the Notary Public witnessing the individual's signature.**

The State of \_\_\_\_\_ the Parish / County of \_\_\_\_\_  
Before me, a Notary Public, on this day personally appeared \_\_\_\_\_ known to me  
(or proved to me on the oath of \_\_\_\_\_) to be the 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. \_\_\_\_\_.