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. _____.