MEDICAL INFORMATION AND RELEASE FORM
FIRST UNITED METHODIST CHURCH CORAL GABLES

(Team Leader: Please keep the original copy)

Foreign Trips: The name you use MUST EXACTLY MATCH the name on your **passport.**

NAME _____

ADDRESS _____

HOME OR CELL PHONE _____

WORK PHONE _____

EMAIL _____

PASSPORT # _____ (NEEDED ONLY FOR INTERNATIONAL TRIPS)

EXPIRATION DATE _____

DRIVER'S LICENSE # _____

STATE _____

DATE OF BIRTH _____

AGE _____

MALE _____ FEMALE _____

SIGNATURE OF PARTICIPANT: _____ DATE: _____

PARENT/GUARDIAN SIGNATURE: _____

PARENT'S FULL NAME, PRINTED CLEARLY! _____
(IF APPLICANT IS UNDER AGE 18)

NOTE: THE TEAM LEADER WILL RETAIN IN HIS/HER POSSESSION THESE MEDICAL FORMS FOR THE PURPOSE OF SHARING INFORMATION TO LICENSED PROFESSIONALS SHOULD A MEDICAL EMERGENCY ARISE.

CONSENT FORM
FIRST UNITED METHODIST CHURCH CORAL GABLES
(Team Leader: Please keep the original copy)

PERMISSION (INCLUDING THE APPLICANT UNDER AGE 18):

Expenses are based on best estimates and are subject to change.

In the event of political unrest, or natural disaster, First United Methodist Church of Coral Gables reserves the right to cancel the mission trip or project.

Team members, leaders, and staff strictly adhere to expected standards and policies and are subject to dismissal without refund or reimbursement.

Team members, leaders and staff serve at their own risk and First United Methodist Church of Coral Gables is not liable in the event of illness, accident, death, or terrorist acts, or for transportation or any other expenses beyond that of normal involvement.

All donations received by First United Methodist Church of Coral Gables go towards tax exempt mission expenses. Money cannot be refunded.

Team members, leaders & staff agree to participate in fundraising and promotional activities, as needed.

Signature of Participant's agreement: _____ Date: _____

Parent/Guardian Signature: _____Date: _____
(If applicant is under age 18)

Note: The team leader will retain in his/her possession these medical forms for the purpose of sharing information to licensed professionals should a medical emergency arise.

MEDICAL INFORMATION AND RELEASE FORM
FIRST UNITED METHODIST CHURCH CORAL GABLES

(Team Leader: Please keep the original copy)

NAME (AS SHOWN ON MEDICAL INSURANCE): _____

Departure Date: Monday, June 11, 2018 06/11/2018

Return Date: Sunday, June 17, 2018 06/17/2018

DO YOU HAVE ANY PROBLEMS TAKING PREVENTIVE MEDICINES SUCH AS ANTI-MALARIAS, OR IMMUNIZATIONS COMMONLY RECOMMENDED FOR TRAVEL IN SOME PARTS OF THE WORLD?

NO _____ YES_____ IF YES, PLEASE EXPLAIN: _____

_____

DO YOU USUALLY EXPERIENCE GOOD HEALTH? YES _____ NO _____

BLOOD TYPE: _____

I, _____ authorize if I am unable to do so, to consent to any necessary examination, anesthetic, medical diagnosis, surgery, or treatment and/or hospital care rendered to me under the general or special supervision and on the advice of any physician and surgeon licensed to practice medicine by the state or country in which they practice, during the duration of the trip identified above.

SIGNATURE: _____ DATE _____

PRINT NAME CLEARLY: _____ DATE _____

PARENT/GUARDIAN SIGNATURE: _____ DATE _____

PARENT'S NAME PRINTED CLEARLY: _____ DATE _____

MEDICAL INFORMATION AND RELEASE FORM
FIRST UNITED METHODIST CHURCH CORAL GABLES

(Team Leader: Please keep the original copy)

MEDICAL & INSURANCE INFORMATION

Medical Insurance Carrier: _____

Policy Number: _____

Family Physician: _____

Telephone: _____

Email: _____

Have you ever been treated or seen by a physician for (check applicable boxes and explain below)?

None	Allergies	Asthma
Bronchitis	Chest Pain	Diabetes
Dizziness	EENT Disease	Emotional Problems
Heart trouble	Hernia	High Blood Pressure
Kidney trouble	Sinusitis	Stomach Upset
Stroke	Ulcer	Other (explain below)

Immunizations:

Tetanus
Date Received: _____

Typhoid
Date Received: _____

☐ Other:_____

LIST ANY PRESCRIPTION DRUGS YOU WILL BE TAKING WHILE ON THE TRIP; STATE THE PURPOSE, FREQUENCY, AND DOSAGE FOR EACH:

_____

_____

_____

_____

_____

EMERGENCY NOTIFICATION
FIRST UNITED METHODIST CHURCH CORAL GABLES
(Team Leader: Please keep the original copy)

NAME OF PERSON TO BE CONTACTED: _____

RELATIONSHIP TO PERSON: _____

PHONE NUMBERS CELL_____

WORK_____

HOME _____

HAVE YOU NOTIFIED THIS PERSON OF YOUR TRAVELING PLANS TO PARTICIPATE IN THIS MISSION TRIP?
YES _____ NO _____

2) NAME OF PERSON TO BE CONTACTED: _____

RELATIONSHIP TO PERSON: _____

PHONE NUMBERS: CELL _____

WORK _____

HOME: _____

MEDICAL HISTORY
FIRST UNITED METHODIST CHURCH CORAL GABLES
(Team Leader: Please keep the original copy)

PHYSICAL DISABILITIES - HEALTH PROBLEMS (INCLUDE TYPE OF MEDICATIONS PRESCRIBED)

_____

_____

_____

_____

_____

DIETARY RESTRICTIONS AS RELATED TO MEDICAL PROBLEMS

_____

_____

_____

INDICATE WHETHER YOU HAVE SPECIAL NEEDS REGARDING SLEEPING ACCOMMODATIONS, MEALS:

_____

_____

_____

PRINT NAME OF PARTICIPANT: _____

SIGNATURE OF PARTICIPANT: _____ DATE ____/_____/____

SIGNATURE OF PARENT: _____ DATE ____/_____/____
(For youth under 18 years old)

Notarization of Medical Release Form

STATE OF_____ PARISH OR COUNTY OF _____ On this _____ day of _____, _____ (year), before me personally appeared _____ to me known to be the same person described in and who executed the within instrument, and who acknowledged the same to be the free act and deed thereof.

Notary Public _____ County/Parish _____ State of _____ My Commission Expires _____

☐ I do hereby verify that the below information is correct and I do hereby grant permission for the church to obtain medical attention in case of sickness or injury.

I hereby grant permission for an attending physician or hospital to perform whatever care deemed necessary by the church for my welfare should I be unable to make reasonable and sound decisions for myself.

RELEASE AND WAIVER. I HEREBY RELEASE, ABSOLVE, INDEMNIFY, HOLD HARMLESS, AND FOREVER DISCHARGE FIRST UNITED METHODIST CHURCH OF CORAL GABLES AND THEIR RESPECTIVE STAFFS, TRUSTEES, MEMBERS, ORGANIZERS, SPONSORS, AND SUPERVISORS (COLLECTIVELY, THE "CHURCH") FROM ANY AND ALL CLAIMS, DEMANDS, ACTIONS OR CAUSE OF ACTIONS, PAST, PRESENT, OR FUTURE ARISING OUT OF INJURY OR DAMAGE INCURRED BY PARTICIPANT WHILE PARTICIPATING ON THIS TRIP. I FURTHER WAIVE ANY RIGHT I MAY HAVE WITH RESPECT TO THE CLAIMS OR DEMANDS FROM WHICH THE CHURCH IS HEREWITH RELEASED AND ANY RIGHT TO FILE ANY CHARGE OR COMPLAINT AGAINST THE CHURCH WITH RESPECT THERETO.

ASSUMPTION OF RISK. I ASSUME ALL RISKS AND HAZARDS INCIDENTAL TO THE CONDUCT OF THE ACTIVITIES AND TRANSPORTATION TO AND FROM THE AREA. IN CASE OF INJURY TO ME, I HEREBY WAIVE ALL CLAIMS AGAINST THE CHURCH. I LIKEWISE I RELEASE FROM RESPONSIBILITY ANY PERSON TRANSPORTING ME TO AND FROM THE ACTIVITIES.

Signed: _____ Date: _____

PHYSICIAN'S RELEASE FORM
FIRST UNITED METHODIST CHURCH CORAL GABLES
FORM TO BE COMPLETED IF EXISTING MEDICAL CONDITIONS ARE DISCLOSED

I plan to participate in a Volunteers in Mission project in:
_____(location of project).

I will be doing manual labor outside in a climate that is:

HOT AND HUMID

1. An antibiotic for the treatment of bacteria diarrhea may be prescribed.

2. Malaria prophylaxis is indicated in certain parts of the world. Recommendations for protection against malaria and other diseases may be obtained by calling the Center for Disease Control (CDC) 24 hour hotline at: 800.232.4636 or 800.CDC.INFO.

Please sign below if you agree that my general health is adequate for this endeavor. If you are not familiar enough with my physical health, I agree to have a physical examination and laboratory tests if indicated as part of my application process.

After reviewing the above information and knowing the team member, it is my opinion that not untoward risks would be incurred by this person's participating in a project as described above.

SIGNED _____, MD Physical

PRINT NAME: _____

EXAMINATION PERFORMED _____YES _____NO

ADDRESS _____

PHONE _____