CrossRoads Missions

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www.crossroadsmissions.com

FORM D

For Ages 18 and older

Medical, Dental and Photography Permission Form for Adult. **Please print a copy of this form to have it notarized. Once notarized give this form to your Trip Leader.**

Group/Trip Name: _____ Date: _____

Ministry Field: ☐ Appalachia ☐ Inner City ☐ Mexico ☐ New Orleans

Name: _____ Nickname: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ SSN: _____ ☐ Female ☐ Male

Home Phone: _____ Cell Phone: _____ Email: _____

Father/Guardian Name: _____

Address: _____ SSN: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Mother/Guardian Name: _____

Address: _____ SSN: _____

Home Phone: _____ Cell Phone: _____ Email: _____

Please provide employment information for your parent or guardian unless your insurance coverage is provided by your own employer.

Employer Name/Address: _____

Employer Contact Name: _____ Telephone: _____

Health Provider / Insurance Information - Medical/Health Insurance is required!

Insurance Carrier: _____ Policy #: _____

Name of Policy Holder: _____

IMPORTANT

- Include a copy of your current insurance card with this form.

- If you are traveling to our Mexico ÿeld, please include a copy of your *passport*.

Please list all prescribed and over-the-counter medication(s) used.

Please list any allergies, including **medicine, food and insect allergies**.

Date of your most recent Tetanus immunization:

In event of an emergency, please notify:

Name:

Address:

Home Phone:

Cell Phone:

Please check any of the conditions or symptoms listed below that you have, are being treated for or have had in the past five years.

- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Irregular Heartbeat
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Epilepsy
- ☐ Bleeding Disorder
- ☐ Anemia
- ☐ Asthma
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Anorexia/Bulemia
- ☐ Cancer
- ☐ Skin Problems
- ☐ Frostbite/Cold Tolerance
- ☐ Circulation Concerns
- ☐ Broken Bones
- ☐ Arm/Shoulder Problems
- ☐ Knee/Ankle Problems
- ☐ Neck/Back Problems
- ☐ Leg/Foot Problems
- ☐ Headaches
- ☐ Head Injury
- ☐ Nuerological Concerns
- ☐ Jaundice
- ☐ Heat Intolerance / Stroke
- ☐ Bladder Problem
- ☐ Kidney Problem
- ☐ Thyroid Problems
- ☐ Endocrine Problems
- ☐ Hearing Impaired
- ☐ Vision Impaired
- ☐ Wheelchair Bound
- ☐ Motion Sickness
- ☐ Sleep Walking
- ☐ Currently Pregnant
- ☐ Special Diet
- ☐ Learning Disability
- ☐ Medical Equipment
- ☐ Stomach Ulcers
- ☐ Intestinal Problems
- ☐ Active Bedwetting
- ☐ Chest Pain
- ☐ Heart Palpitations
- ☐ Unexplained Sweating
- ☐ Shortness of Breath
- ☐ Dizziness
- ☐ Fainting
- ☐ Cramping

For any checked item above, please indicate that item below and provide the following information: frequency, duration, treatement, date of last occurence or any other information for which we should be aware.

By signing this form, I do hereby grant and convey to CrossRoads Missions, its partners and affiliates, all right, title and interest in any and all photographic images, video and audio made by CrossRoads Missions during for participation in activites identified by or related to this form. This includes, but is not limited to royalties, proceeds or other benefits derived from such materials.

Furthermore, I, for myself and the named participant on this form, and on behalf of my estate, heirs, executors and administrators do hereby fully release and discharge CrossRoads Missions, including their partners and affiliates, from any and all liabilities, claims, obligations, damages and causes of action whatsoever arising or growing out of my travel and/or participation in the programs of CrossRoads Missions. I also understand that I am responsible for all medical bills related to such activity. Should it be necessary for me to return home due to medical reasons or disciplinary action, I will assume total responsibility for all transporation costs to and from the event. I understand, that as a CrossRoads Missions participant, that I am serving at my own risk and that CrossRoads Missions is not liable in the event of sickness, injury, accident, theft, terrorist acts or death.

I, hereby consent and authorize CrossRoads Missions, its partners, affiliates, agents and designess, to authorize any medical treatment deemed necessary while participating in any activity applicable to this form should the named participant be mentally and/or physically incapable of making such a decision. My signature likewise indicates that the information that I have provided on this application is true and accurate and that I have read this entire document, understand it completely and agree to the conditions and terms stated herein.

This form should only be signed in the presence of a Notary who is licensed in your state of residence.

Printed Name: _____

Signature: _____

Date: _____

Notary

Subscribed and sworn to before me this _____ day of _____ , 20 ____

Notary: _____

My commission expires ___ / ___ / ____

Seal: