



Mission Trip Medical Forms (Due November 1)

CHECKLIST

Please go through this entire folder with this Checklist and do the following:

- Apply for your **Passport** immediately if you have not already and provide copy of passport with paperwork.

- Consent for Medical Treatment; Release and Hold-Harmless For Travel** (Note: If parents have joint custody, we must have both parents' signatures.) **THIS FORM MUST BE NOTARIZED.**

- Complete the **Medical Insurance Verification** and apply for **International Travel Insurance** if necessary.

- Fill out **Medical Information and Checklist** entirely.

- Deliver all signed forms and information to Chris Searcy (drama teams) or Ann Smith (Liberty Chorale).**

Missionary Name _____ Date _____

CONSENT FOR MEDICAL TREATMENT; RELEASE AND HOLD-HARMLESS FOR TRAVEL

WHEREAS, (my child/I) _____, wishes to be a member of Liberty Christian School mission trip, which will be traveling to and staying in Ireland, and WHEREAS, certain circumstances and situations may occur resulting in (my child's, my) need for medical/dental care and treatment, and further resulting in my inability to personally give consent for such care and treatment; THEREFORE,

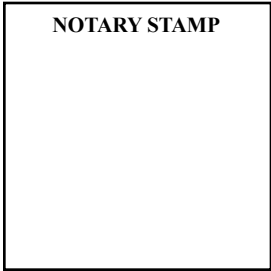
1. In consideration of permission for (my child, myself) to participate in said mission. I _____, being of legal age, authorize Liberty Christian School, or any agent of Liberty Christian School, to act in (my child's, my) behalf should I be unable to do so and to consent to reasonable medical/dental care and treatment, including but not limited to diagnostic tests, x-ray examination, anesthesia, surgery, or other procedures which may be deemed necessary for (my child's, my) medical well-being for the duration of the mission.
2. This consent is given in advance of any specific diagnosis, treatment, surgery, or hospital care required, but is given to provide authorization and specific consent for medical/dental treatment and care in (my child's, my) behalf.
3. Any consent by Liberty Christian School shall have the same force and effect as if I had personally given the consent.
4. I certify that I have personal health insurance with (Must provide **proof** of medical insurance.)

Company Policy # _____
with no territorial limitation, including foreign countries, which will provide coverage for (my child/me) throughout the duration of said mission. If my company policy does not include international coverage including **\$25,000 emergency evacuation** coverage, I understand that no health plan is provided by Liberty Christian School and therefore have enrolled in the INTER-MEDICAL insurance plan.

5. I am aware that serious illness requiring return by air ambulance could cost more than \$10,000. I agree that I am solely responsible for any expenses that may arise from (my child's, my) return by air ambulance or other extraordinary means.
6. I hereby release and hold harmless Liberty Christian School, 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 child's, my) participation in this trip. **(If you are under custody of both parents, we need both parents' signatures.** If you are not, we need the signature of the parent who has custody. Some foreign countries require this.)

_____ Father's signature (if applicant is under 18 years of age)	_____ Date
_____ Mother's signature (if applicant is under 18 years of age)	_____ Date
_____ Guardian's signature (if applicant is under 18 years of age)	_____ Date
_____ Applicant's signature	_____ Date

State of _____.
County of _____.
Before me, the undersigned, a Notary Public in and for said county and state on _____, 200__, personally appeared the identical person who executed the within and foregoing instrument, and acknowledged to me that he/she executed the same as his/her free and voluntary act and deed, for the uses and purposes therein set forth. Given under my hand and seal of office the day and year above written.



My commission expires: ___/___/___ Notary Public

MEDICAL INSURANCE VERIFICATION

If you have insurance coverage that extends to international travel, it must also include \$25,000 emergency evacuation coverage, repatriation of remains and accidental death & dismemberment.

If you do not have coverage that includes international travel, we recommend the enclosed plan (see form). This covers international travel for the duration of the time abroad.

Please provide us with the following information:

_____ I have full coverage, both domestic and international **including** \$25,000 emergency evacuation coverage, repatriation of remains and accidental death & dismemberment.

Company _____ **Policy #** _____

_____ I have domestic coverage.

Company _____ **Policy #** _____

_____ My U.S. plan does not cover international travel & emergency evacuation. I have enrolled in the enclosed insurance plan.

Policy # _____

Missionary's Name _____

Signed _____

Date _____

(By parent if missionary is under 18)

MEDICAL INFORMATION AND CHECKLIST

Name _____ Age _____ Birthday ____/____/____ Sex ____M ____F

Address _____ Weight _____ Height _____

City _____ State _____ Zip _____

Phone # (____) _____ Work # (____) _____ Blood Pressure (optional) _____

Insurance policy name _____ Policy # _____

In case of an emergency contact:

1. Name _____ Phone # (____) _____
 Address _____ Cell # (____) _____
 City _____ State & Zip _____

2. Name _____ Phone # (____) _____
 Address _____ Cell # (____) _____
 City _____ State & Zip _____

Childhood Immunizations (These must be up-to-date.)

Yes	No	Type	Year
___	___	Mumps/Measles/Rubella	___
___	___	Diphtheria/Pertussis/Tetanus	___
___	___	Polio	___
___	___	Tetanus	___
___	___	Other _____	___

ALL QUESTIONS MUST BE ANSWERED. ANY MISREPRESENTATION WILL VOID YOUR ACCEPTANCE.

Has a doctor ever treated you for any of the following (every item must be checked)?

Yes	No	
___	___	Asthma or chronic wheezing
___	___	Emphysema or other lung and/or respiratory problems
___	___	Chronic persistent cough or shortness of breath
___	___	Tuberculosis
___	___	Any skin disorder or disease other than acne
___	___	Chronic/recurrent ear or eye problems
___	___	Impairment of hearing or vision. Meniere's Disease, cataracts or glaucoma
___	___	Persistent, recurring indigestion, stomach or duodenal ulcers
___	___	Gall bladder stones or colic
___	___	Jaundice, cirrhosis or other liver problems
___	___	Intestinal or bowel problems, colitis, diverticulitis, hemorrhoids, other rectal problems or bleeding
___	___	Any test results indicating exposure to the AIDS virus
___	___	Albumin, blood or pus in the urine; painful or frequent urination; or kidney problems
___	___	Diabetes or hypoglycemia (low blood sugar)
___	___	Mental health counseling or psychiatric treatment
___	___	Rheumatism, gout, arthritis or other forms of swollen painful joints
___	___	Chronic back pain, back injury or surgery; sciatica, scoliosis or other bone or joint disorder
___	___	Cysts, tumors or growths of any kind, hernia or rupture
___	___	Cancer
___	___	Fainting spells, dizziness, convulsions, epilepsy or seizure disorder
___	___	High blood pressure, heart murmurs or other cardiac problems
___	___	Vein or circulatory trouble
___	___	Severe migraine headaches
___	___	Goiter, thyroid ailment, high or low metabolism
___	___	Anemia or other blood disorder
___	___	Abnormality of reproductive systems, prostate problems, breast disorder, menstrual disorders, or venereal disease
___	___	Parkinson's Disease
___	___	Severe knee injury or problems (THIS IS VERY IMPORTANT DUE TO THE NATURE OF THE DRAMA.)
___	___	Severe allergic reactions to either food, medicines, bee stings or any other insect bite or sting
___	___	Any other diseases, deformity, or disability not listed above

IF YOU CHECKED "YES" TO ANY OF THE ITEMS ON THE PREVIOUS PAGE YOU ARE REQUIRED TO HAVE YOUR DOCTOR:

1. SEE AND SIGN THIS COMPLETED FORM.
2. COMPLETELY FILL OUT THE DOCTOR'S RELEASE. IF YOU DON'T, YOUR ACCEPTANCE WILL BECOME VOID.

CONTINUE: Please complete the following questions:

Are you currently taking any prescribed medication? Yes _____ No _____ If yes, please specify the medication and the dosage. _____

Are you currently using any non-prescription drugs on a regular basis; such as antihistamines, sleeping aids? Yes _____ No _____ If yes, please specify. _____

Have you ever received treatment or 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. _____

Family Medical History

Do any of your grandparents, parents, or siblings have:

Yes	No		If yes, who?
_____	_____	Diabetes	_____
_____	_____	Hypertension	_____
_____	_____	Heart Disease	_____
_____	_____	Depression	_____
_____	_____	Mental Illness	_____

What was the date and who was the attending physician of your last physical exam? _____

List all surgical operations or hospitalizations you have undergone.

1. **Operation**, illness and reason _____ Date _____

Name of address of hospital _____

Name of physician _____

Remaining effects _____

2. **Operation**, illness and reason _____ Date _____

Name of address of hospital _____

Name of physician _____

Remaining effects _____

If you have been hospitalized more than two times, please explain. _____

Please provide any details pertaining to your health not covered by the above questions. _____

Applicant's signature _____ Date _____

Parent's signature _____ Date _____

DOCTOR'S RELEASE FORM (if necessary)

I have reviewed this patient's Medical Information & Checklist form and medical history, and I have performed a physical exam. I find him/her to be in suitable condition for international travel, participation in high-intensity activities (i.e., hiking several miles and conditions in a third world country.)

Physician's signature _____ Date _____

Doctor's Name _____ Phone _____

Address _____

DIABETICS, at times there will be limited access to supplies for specialized diets. Sometimes the diet will be unpredictable.