MEDICAL RELEASE

PERSONAL INFORMATION

LAST NAME	FIRST NAME	BIRTHDATE

STREET ADDRESS	APT/UNIT

CITY	STATE	ZIP

PHONE	EMAIL

MISSION TEAM LEADER	DATES OF TRIP

EMERGENCY CONTACT

NAME	RELATIONSHIP

HOME PHONE	MOBILE PHONE

MEDICAL HISTORY AND INSURANCE

DATE OF LAST TETANUS	PHYSICIAN	PHONE

MEDICAL INSURANCE PROVIDER

PHONE	POLICY NUMBER	GROUP NUMBER

Do you have any physical limitations or emotional disorders? Please explain.

Do you have any medical problems? Please explain.

Have you had surgery in the past 12 months? Please explain.

Are you taking any prescription or non-prescription medicine on a regular basis? Please list.

Are you allergic to any medication or food? Please explain.

MEDICAL RELEASE

I ______________________________________, will be traveling to Nicaragua to minister with Twelve Churches, Inc. to the people in and around Leon. If I need medical attention, I give the Twelve Churches staff the right to give consent to authorize emergency medical care. It is intended that this document be presented to the physician or appropriate hospital or medical representative at such times as the medical care shall be authorized. It is intended that the authorization release the physician, dentist, person rendering such care at the hospital or institution in which such care is given and Twelve Churches from any liability resulting from the failure of me signing a consent or authorization to render such care. It is the intent that Twelve Churches' staff shall act in my stead in making such decisions.

I have put the important medical facts, if any, on this form. The medical facts are intended to help the doctor in deciding what treatment is to be given, but are in no way intended to restrict the giving of authorization or consent by Twelve Churches' staff. I understand that this form is in effect from the departure of the intern to arrival back to the city of departure.

Date ________________ Signature ____

Date ________________ Parent Signature ____
IF UNDER THE AGE OF 18

Parent Name in Print ____

NOTARIZATION OF MEDICAL RELEASE FORM

ATTENTION NOTARY PUBLIC: YOU ARE NOTARIZING THE SIGNATURE OF THE PARENT IF THE APPLICANT IS UNDER 18 YEARS OF AGE.

State of ___________________________________

County of _________________________________

On this ______________day of_____________________________, 20____, before me personally appeared _________________________________ personally known to me (or providing the following identification) ______________________________and who executed the within instrument, and who acknowledged the same to be the free act and deed thereof.

Notary signature ___________________________________

My commission expires ____________________________

RELEASE OF CLAIM

PERSONAL INFORMATION		
LAST NAME	FIRST NAME	BIRTHDATE
STREET ADDRESS		APT/UNIT
CITY	STATE	ZIP
PHONE	EMAIL	
CHURCH ORGANIZATION		
OCCUPATION	PASSPORT NUMBER	

EMERGENCY CONTACT	
NAME	RELATIONSHIP
HOME PHONE	MOBILE PHONE

STATEMENT OF ACTIVITIES AND RELEASE

I ______________________________________, hereby release and discharge Twelve Churches, Inc. and the mission organizations which assisted in these arrangements, their agents, employees, and officers, from all claims, demands, actions, judgments, and executions which I ever had, or now have, or may have, or which my heirs, executors, administrators, or assigns may have or claim to have, against the missions organizations, their agents, employees, and officers, and their successors or assigns for all personal injuries to property, real or personal, caused by, or arising out of mission service. I intend to be legally bound by this statement.

I hereby acknowledge that by engaging in this mission, I am subjecting myself to certain risks voluntarily, including and in addition to those risks which I normally face in my personal and business life, including but not limited to such things as health hazards due to poor food and water, diseases, pests, and poor sanitation; potential danger from lack of control over local population; potential injury while working; and inadequate medical facilities, etc.

Witness whereof,
I have executed this agreement and release at ____

Date ________________ Signature ____