



CONSENT FOR MEDICAL TREATMENT RELEASE AND HOLD-HARMLESS FOR TRAVEL

WHEREAS, (my child / I)

_____ wishes to be a member of a Teens In Mission Evangelism International (T.I.M.E. International) missionary group which will be traveling to and staying in _____ (country), 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 Teens In Mission evangelism International (T.I.M.E International) or any agent of Teens In Mission Evangelism International (T.I.M.E. International), 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 test, 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, surety, 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 Teens In Missions Evangelism International (T.I.M.E. International) shall have the same force and effects if I had personally given the consent.
4. I certify that I have personal health insurance with _____ (Company) Policy # _____. I understand that no health plan is provided by T.I.M.E. International. If this is desired, it is the responsibility of the parent/guardian to provide.
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 Teens In Mission Evangelism International (T.I.M.E. International), 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 one who has custody of you. Some foreign countries require this.

(My child's / My) Passport # is _____ Country of passport _____

If not a USA passport, # of Resident Alien Card _____

Father's name and signature if applicant is under 18 years of age Date: _____

Mother's name and signature if applicant is under 18 years of age Date: _____

Legal Guardian's name and signature if applicant is under 18 years of age Date: _____

Applicant's name and signature Date: _____

State of _____ County of _____

Before me, the undersigned, a Notary Public in and for said country and state on _____, 2004, 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. Give under my hand and seal of office the day and year above written.

Notary Public

My commission expires _____

MEDICAL INFO. & CHECKLIST

Name _____ Social Security # _____

Address _____

City _____, State _____ Zip _____

Home Phone _____ Work Phone _____

Birthdate _____ Age _____

Sex: Male Female Weight _____ Height _____

Health Insurance Company _____

Policy # _____ If no medical insurance, please check here _____

In Case of emergency contact:

Name _____ Phone _____

Name _____ Phone _____

Last Tetanus Shot _____ (Current Tetanus shot is required)

SECTION A:

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

Have you been treated by a doctor for any of the following in the last 3 years? (Every item must be checked)

- | Yes | No | |
|-------|-------|---|
| _____ | _____ | Asthma or chronic wheezing |
| _____ | _____ | Emphysema or other respiratory problems |
| _____ | _____ | Chronic coughing or shortness of breath |
| _____ | _____ | Any skin disease other than acne |
| _____ | _____ | Chronic/recurrent ear or eye problems |
| _____ | _____ | Persistent, recurrent indigestion, stomach ulcers |
| _____ | _____ | Gall bladder stones or colic |
| _____ | _____ | Intestinal or bowel problems, colitis, diverticulitis, hemorrhoids, or any other rectal problems or bleeding, IBS |
| _____ | _____ | Diabetes or hypoglycemia (low blood sugar) |
| _____ | _____ | Serious bodily injury |
| _____ | _____ | Mental health counseling or psychiatric treatment |
| _____ | _____ | Rheumatism, gout, arthritis, or swollen painful joints |
| _____ | _____ | Chronic back pain, back injury or surgery; sciatica, scoliosis or other bone and 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 headaches or migraines (Prescription Medication ___ / Over the Counter Medication ___) |
| _____ | _____ | Anemia or any other blood disorder including Hymophilia or HIV |

____ Parkinson's Disease
____ Severe knee injury or problems
____ Severe allergic reaction to either food, medicine, bee stings,
or any other insect bite or sting
____ Any other disease, problem, or disability not listed above
(explain) _____

IF YOU HAVE ANSWERED YES TO ANY OF THESE PLEASE PROVIDE MORE DETAILS:

SECTION B:

Please complete the following questions in addition to the medical checklist:

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

Do you use an inhaler? Yes _____ No _____ If yes, how often? _____

Are you currently using any non-prescription drugs on a regular basis; such as antihistamines, sleeping aids, etc?

Yes _____ No _____ If yes, please specify. _____

Have you ever received treatment or counseling for alcohol or chemical abuse?

Yes _____ No _____ If yes, when and where _____

Are you presently under a physician's care for any illness? Yes _____ No _____

If yes, please explain _____

Family Medical History

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

Yes	No	
_____	_____	Diabetes
_____	_____	Hypertension
_____	_____	Heart disease
_____	_____	Depression
_____	_____	Mental Illness

If yes, who? _____

Please provide any details pertaining to your health not covered by the previous information:

(For example: Personal hospitalization in the past 3 years, etc)

DIABETICS: there will be limited access to supplies for specialized diets at times. The diet could be unpredictable.

_____ date _____

Applicant's signature

_____ date _____

Parent's signature