Mount Pleasant Baptist Church

Adult Medical Release and Permission Form

**Attach a copy of your insurance card (front and back) to this form.**

Event Name \_\_\_\_\_Liberty Texas Mission Trip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates \_\_July 20-28 2018\_\_\_\_

Name of Participant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Numbers (H)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (C)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (W) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Permission (initial each)

\_\_\_\_\_ I do hereby verify that the below information is correct and I do hereby grant permission for the

organization to obtain medical attention for myself in case of sickness or injury.

\_\_\_\_\_ I hereby grant permission for an attending physician or hospital to perform whatever care deemed

necessary should I be unable to be to make a reasonable and sound decision for myself.

\_\_\_\_\_ I hereby release, absolve, indemnify, hold harmless, and forever discharge the organization, the

organizers, sponsors, supervisors, and drivers from any and all claims, demands, actions or cause

of actions – past, present, or future – arising out of injury or damage while participating.

\_\_\_\_\_ I assume all risks and hazards incidental to the conduct of the activities and transportation to and

 from the event.

\_\_\_\_\_ I agree to provide medical insurance or I don’t have insurance, but understand I am responsible

 for any medical expenses that may occur.

**Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Emergency Notification

Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to participant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Numbers \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to participant \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Numbers \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Information

Health Insurance Company \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

**Have you ever been treated by a doctor for any of the following:**

**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

\_\_ \_\_ Bronchitis

\_\_ \_\_ Impairment of hearing or vision: Meniere’s Disease, cataracts, or glaucoma

\_\_ \_\_ Persistent, recurring indigestion, stomach, or duodenal ulcers

\_\_ \_\_ Gall bladder stones or colic issues

\_\_ \_\_ 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)

\_\_ \_\_ Serious bodily injury

\_\_ \_\_ 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

\_\_ \_\_ Veinous 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

\_\_ \_\_ 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 answered "yes" to any of the above questions, please explain below

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMMUNIZATIONS**

The following list contains common travel immunizations. This is not a comprehensive list of required

immunizations for your mission trip. It is solely the traveler's responsibility to obtain information on

required/recommended travel immunizations and travel precautions for the area you are visiting. Please

check with your physician and/or www.cdc.gov to ensure your immunizations are current.

**Have you received and/or plan to receive the following immunizations?**

**Yes No Type Year/Allergies**

\_\_ \_\_ Mumps/Measles/Rubella \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ \_\_ Diphtheria/Pertussis/Tetanus \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ \_\_ Polio \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ \_\_ Tetanus \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ \_\_ Hep. A \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ \_\_ Hep. B \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ \_\_ Typhoid \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ \_\_ Rabies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ \_\_ Yellow Fever \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ \_\_ Meningococcus \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ \_\_ Influenza \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Malaria pills are encouraged for some locations, such as South Africa and Ecuador.

List any prescription drugs your child may need. Include frequency and dosage for each.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List all surgical operations or hospitalizations you have undergone.**

1. Operation, illness, reason, and date:

Name and address of hospital:

Name of physician:

Remaining effects:

2. Operation, illness, reason, and date:

Name and address of hospital:

Name of physician:

Remaining effects:

If you have been hospitalized more than two times, please give an explanation.

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

**FAMILY MEDICAL HISTORY**

Do your grandparents, parents, or siblings have:

Diabetes \_\_Yes \_\_No

Hypertension \_\_Yes \_\_No

Heart Disease \_\_Yes \_\_No

Depression \_\_Yes \_\_No

Mental Illness \_\_Yes \_\_No

If yes, who?

**ALLERGIES AND DIETARY RESTRICTIONS**

List any allergies and your reaction.

ALLERGY: REACTION:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY AUTHORIZATION**

I hereby give permission to the medical personnel selected by MPBC and/or UNPES, their designee or the participant’s team leader(s) to order X-rays, routine tests, and treatment for

myself/my child. In the event of an emergency and neither the secondary contact or myself can be

reached, I hereby give permission to the physician selected by MPBC and/or UNPES, their designee or the participant’s team leader(s) to hospitalize, secure proper treatment, order

injections and/or anesthesia and/or surgery for myself/my child as named above.

I further authorize the release of the above medical information to appropriate medical personnel and/or

the health coverage insurance company.

The Health History is correct, so far as I know, and the person herein described has permission to engage

in all prescribed activities except as noted.

Signature of Participant\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Parent/Guardian\*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*Participants under 19 years old must have a parent/guardian signature.

**NOTARY INFORMATION**

The following to be completed by the notary witnessing parent/guardian and/or participant’s signature.

The State of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ the County of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Before me, a Notary Public, on this day personally appeared\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ known

to me (or proved to me on the oath of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) to be the

person whose name is subscribed to the foregoing instrument and acknowledged to me that he executed

the same for the purpose and consideration therein expressed.

Given under my hand and the seal of the office this \_\_\_\_ day of \_\_\_\_\_\_\_\_\_\_, A.D.\_\_\_\_\_.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Notary Public, Signature

My commission expires the\_\_\_\_\_\_ day of\_\_\_\_\_\_\_\_\_\_\_, A.D.\_\_\_\_\_\_\_\_.