International Medical Release Form

This form should be kept by the group leader and not turned in to Servant Life. Place this in the Paperwork Binder provided by Servant Life to take with you while you are traveling.

Church Name:______________________________City/State:______________________________

PERSONAL

Name:____

Birthdate:_____/_____/_______ Age:_________ Gender (M/F):______________

Address:____

City:______________________________ State:______________ Zip:________________

In case of emergency contact:

1. Name: _________________________ Relationship: _______________Phone: (__) __________

2. Name: _________________________ Relationship: _______________Phone: (__) __________

HEALTH INSURANCE INFORMATION

Medical Insurance Co.:____________________________ Group#:__________________________

Policy#:____________________________ Company's Phone:(____)________________________

Company's address:____

City:________________________________ State: __________________ Zip:________________

Family Physician's Name:__________________________________ Phone:(____)______________

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? (We do not need to see immunization records. All we need is the following section to be completed.)

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.

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
__ __ 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 on a separate sheet of paper and completely fill out the **Doctor's Release Form**.

• Are you currently taking any prescribed/non-prescription medication on a regular basis?___Yes ___No
If yes, please specify the medication and the dosage. ____

____

• Have you ever received treatment/counseling for alcohol/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.____________________

• 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, 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:

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

EMERGENCY AUTHORIZATION

I hereby give permission to the medical personnel selected by Servant Life and/or Clubhouse Guatemala, 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 Servant Life and/or Clubhouse Guatemala, 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 18 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.________.