

**FORM B – MEDICAL INFORMATION AND RELEASE**

Central United Methodist Church, 1501 Massachusetts Street, Lawrence, Kansas 66044

Location: Omaha, Nebraska

Dates: July 17 - July 22 (Sun. - Fri.)

**FORM MUST BE COMPLETED IN FULL. PLEASE ANSWER ALL QUESTIONS.**

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Blood Type: \_\_\_\_\_

Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Additional Physician: \_\_\_\_\_

Phone: \_\_\_\_\_

Health Insurance Company Name: \_\_\_\_\_

Policy Number: \_\_\_\_\_

Insurance Contact and Phone Number: \_\_\_\_\_

Supplemental Health Insurance Co. (if any): \_\_\_\_\_

Policy Number: \_\_\_\_\_

Insurance Contact and Phone Number: \_\_\_\_\_

Emergency contact name: \_\_\_\_\_

Phone: \_\_\_\_\_ Relationship: \_\_\_\_\_

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Mission trips can be extremely strenuous and stressful. They may include long plane, train or bus rides of 10 to 20 hours in duration. Travelers are required to carry their own luggage. Restrooms are not always readily accessible. There can be a considerable amount of walking between lodging and meeting locations, in addition to the possibility of climbing stairs. Sleeping arrangements may not be comfortable and, in most instances, you will share a room with one or more persons. Climate can vary from extremely hot in summer months to cold in winter, which could affect your overall strength and energy. Air quality may be poor in some locations, and the food may be unique. Water quality also varies. All of these factors have been known to aggravate certain health conditions, and the medical facilities in many countries may not be adequate. We may request a medical statement from your doctor, if there is any concern about your health and this specific mission trip.

1. Do you have any physical conditions that could limit your ability to perform the ministry of this particular mission trip?

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2. Have you had any surgery or major health problems in the past two years? If so, please explain.

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3. Please check if you have any of the following medical conditions:

Arthritis  Asthma  Bleeding Disorders  Chronic Anxiety  Depression  Diabetes  Fibromyalgia

Gastrointestinal disorders  Glaucoma  Hearing/Vision problems  Heart Disease  Hypertension

Hypoglycemia  Migraines  Seizures  Other \_\_\_\_\_

Allergies and/or food restrictions: Please list any and all allergies that a doctor should know about in case of emergency.

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Physical Restrictions: Please list any and all physical restrictions or conditions that restrict your activity.

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Is there anything the Team Leader or designated Medical Person needs to know about the above checked conditions in order to assist you in your comfort and care?

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Current on tetanus vaccination: Yes No If yes, date received \_\_\_\_\_

**Medication:** Please list daily prescription, dosage and frequency.

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

I give a staff member permission to administer over-the-counter medications for those items checked below in the vent that it becomes necessary. Dosages will be administered according to the instructions on the bottle only unless a physician directs otherwise.

Antacids  Cough Medicine/Drops  Benadryl  Tylenol  Advil/Ibuprofen  Aspirin  Sudafed  Neosporin

**Authorization and Waiver**

I, the undersigned, in consideration of the opportunity to participate in the activities of the Central United Methodist Church and related entities and Program Activities (herein the "Church" ) do:

- 1. In the event of any injury of medical emergency affecting my person, authorize and grant to the Church and anyone acting on behalf of the Church the right to provide, approve, seek, and obtain medical care, treatment, and assistance for my person, and,
- 2. Waive all claims or anyone claiming through my person against the Church arising of said Activities.

I understand that this document has significant legal consequences, but I also believe I, the undersigned, will benefit from the Activities of the Church, and, for that reason and in consideration of said benefit; I choose to execute this Authorization and Waiver. I also understand that this will be in effect from June 1 \_\_\_\_\_ to May 31 \_\_\_\_\_ encompassing the date notarized/sworn below.

\_\_\_\_\_  
(Signature)

**STATE OF KANSAS**

Before me, the undersigned authority, on this day personally appeared. \_\_\_\_\_ known to be the person whose name is subscribed above, and acknowledged to me that he/she executed the same for the purpose therein expressed.

Sworn before me this the \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_.

\_\_\_\_\_  
(Signature)

Notary Public for \_\_\_\_\_county

(seal)

My Commission expires \_\_\_\_\_