

FORM B – STUDENT 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: _____

*****Please check the area that applies so your student's needs can be met*****

- | | | | |
|--|---|--|---|
| <input type="checkbox"/> Heart Condition | <input type="checkbox"/> Food Allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Other Allergies |
| <input type="checkbox"/> Daily Meds | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hearing Aid | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Bee Sting Allergy | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Bed Wetting | <input type="checkbox"/> Blood Disorder |
| <input type="checkbox"/> Contacts | <input type="checkbox"/> Seizures | <input type="checkbox"/> Sleep Walking | <input type="checkbox"/> Other Health Problem (please list) |

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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?

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

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.

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

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 _____