

**CONSENT FOR MEDICAL TREATMENT: RELEASE AND HOLD HARMLESS FOR TRAVEL**

Name: \_\_\_\_\_ Birth Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Trip you are traveling: \_\_\_\_\_ Social Security # \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Whereas (I/my child) \_\_\_\_\_, wish(es) to be a member on a Highlands Community Church Short-term Missions Team and will be traveling to and staying in \_\_\_\_\_ (country), and WHEREAS, certain circumstances may occur resulting in (my/my child's) need for medical/dental care and treatment, and further resulting in my inability to personally give consent for such care and treatment: THEREFORE, In consideration of permission from Highlands Community Church International Outreach Ministry for (myself/my child) to participate in said missionary, short-term trip,

I, \_\_\_\_\_, being of legal age, authorize Highlands Community Church, or any designated agent of Highlands Community Church, to act on my, my child's) behalf should I be unable to do so and to consent to all medical/dental care and treatment, including, but not limited to diagnostic test, x-ray, examination, anesthesia, surgery, or other procedures which Highlands Community Church deems necessary for (my/my child's) medical well being for the duration of the mission. This consent is given in advance of my specific diagnosis, treatment, surgery, or hospital care required and to be the administration of any over-the-counter medications including, but not limited to Tylenol, Advil, allergy medications, and is given to provide authorization and specific, consent for medical/dental treatment and care in (my/my child's) behalf. Any consent by Highlands Community Church shall have the same force and effect as if I had personally given the consent.

I certify I have personal health insurance, including foreign countries, with no territorial limitation, for the providing of medical services to (me/my child) which will provide coverage for (me/my child) during the duration of said trip. I understand that Highlands Community Church provides no health plan.

\_\_\_\_\_  
My Insurance Company

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

\_\_\_\_\_  
Insurance Company Phone Number

*I hereby release Highlands Community Church, its agents, servants, employees and assigns for any and all damages, liability or costs resulting from the authorizing of medical treatment on (my child/my) behalf under the terms of this consent. I further hold Highlands Community Church harmless and agree to indemnify Highlands Community Church of any and all costs, damages or expenses incurred by Highlands Community Church as a result of any claim or action filed by any party alleging damages incurred as a result of any medical treatment provided or authorization for treatment provided. I understand that this release and indemnification releases treatment for the conduct of Highlands Community Church and its agents, servants, employees and assigns even if such conduct is negligent.*

**Parent Information (for applicants under 18)**

Name(s) \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Day Phone Number \_\_\_\_\_

Address \_\_\_\_\_

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

In case of emergency and we cannot reach you, who should we contact?

Name \_\_\_\_\_

Home Phone Number \_\_\_\_\_ Day Phone Number \_\_\_\_\_

Address \_\_\_\_\_

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

**Childhood Immunizations**

These must be up to date. Please do not leave blank unless this information is on your yellow immunization card.

YES	NO	TYPE	YEAR ADMINISTERED
		Mumps/Measles/Rubella	
		Diptheheria/Pertussis/Tetanus	
		Tetanus Booster within 10 years	
		Polio	
		Other	

**Please complete the following:**

- Are you currently taking any prescribed medication? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, specify the medication and the dosage \_\_\_\_\_
- Are you currently using any non-prescription drugs on a regular basis, such as antihistamines or sleeping aids?  
Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, specify \_\_\_\_\_
- Have you ever received treatment or counseling for alcohol or chemical abuse? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, specify when and where \_\_\_\_\_
- Are you currently under a physician's care for any illness? Yes \_\_\_\_\_ No \_\_\_\_\_
- If yes, explain. \_\_\_\_\_
- Please give physician's name and the date of your last physical exam.  
Name \_\_\_\_\_ Date \_\_\_\_\_
- List all surgical operations or hospitalizations you have undergone.  
Illness or Operation \_\_\_\_\_  
Reason \_\_\_\_\_

- Please provide any further details pertaining to your health not covered by the above questions. \_\_\_\_\_

**ALL QUESTIONS MUST BE ANSWERED. ANY MISREPRESENTATIONS WILL VOID YOUR ACCEPTANCE**

**Have you ever been treated by a doctor for any of the following?** (Every item must be checked.)

YES	NO		YES	NO	
		Asthma or Chronic Wheezing			Mental Health Counseling Treatment
		Any other Respiratory Problems			Fainting Spells
		Cysts or Tumors of any kind			Convulsions, epilepsy or seizures
		Chronic persistent cough			Parkinson's Disease
		Skin disorder other than acne			Anemia or any other blood disorder
		Goiter			Serious bodily injury
		Diabetes or hypoglycemia (low blood sugar)			Thyroid ailment
		Circulatory trouble			Severe allergic reactions
		Cancer			Any other disease, disability, or deformity not listed
		Hearing or vision impairment			AIDS virus or HIV
		Intestinal or bowel problems			Persistent, recurring indigestion, stomach or duodenal disorders
		Kidney problems			High or low metabolism
		Tuberculosis			Gall Bladder stones or colic
		Rheumatism, arthritis, painful swelling joints			Prostrate problems
		Chronic back pain, injury, surgery, scoliosis			Breast disorder, menstrual disorder, venereal disease
		Severe knee problems			High blood pressure/cardiac problems
		Are you a vegetarian?			

If you checked "YES" to any of the questions on this form, you are encouraged to visit with your doctor and receive his/her medical opinion regarding your ability to travel abroad.

I, \_\_\_\_\_, further authorize Highlands Community Church to release any and all medical information or records necessary (for my child or myself) to any party deemed necessary by Highlands Community Church, its agents, servants, employees and assigns for the providing of medical treatment to (my child/myself) or to members of the missionary group to insure proper placement of (myself/my child) in such a group. I am aware that serious illness or injury may occur on a mission trip and that such illness or injury may result in (myself/my child) incurring costs, expenses and damages for which I am solely responsible including, but not limited to, return of (myself/my child) by air ambulance at a cost of \$10,000 or more.

I agree that I am solely responsible for any expenses that may arise from (my/my child's) return by air ambulance or other extraordinary means. I hereby release and hold harmless Highlands Community Church, 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/my child's) participation in this short-term trip. I have read and understood the above information. The information I give Highlands Community Church is accurate and true to the best of my knowledge.

I also give Highlands Community Church the right to use my picture, voice and/or testimony in any form of promotional or advertising materials. My enclosed signature signifies my approval of all limitations listed above as well as my agreement with the Honor Code Financial Covenant and Discipline Agreement. My signature insures that all information on these forms is completely true and has not been altered in any way.

If you are in legal custody of both parents – both parents' signatures are required.

If you are in the legal custody of one parent – the signature of the one who has legal custody is required and a copy of a legal document evidencing the custody agreement, or a notarized copy of the death certificate for a deceased parent. We apologize for any inconvenience.

X \_\_\_\_\_ Date \_\_\_\_\_  
Short-term Missionary's Signature

X \_\_\_\_\_ Date \_\_\_\_\_  
Guardian's Signature (If applicant under 18)

X \_\_\_\_\_ Date \_\_\_\_\_  
Father's Signature (If applicant under 18)

X \_\_\_\_\_ Date \_\_\_\_\_  
Mother's Signature (If applicant under 18)

Note to Notary: if you do not have a notary stamp, we need other proof of notary such as copy of Notary certificate.  
Notary fills out this section:

State of \_\_\_\_\_, county of \_\_\_\_\_

Before me, the undersigned, a Notary Public in and for said county and state on  
\_\_\_\_\_, 20 \_\_\_\_\_, 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. Given under my hand and seal of office the day  
and year above written.

\_\_\_\_\_  
Notary Public Printed Name

Notary Public Stamp

\_\_\_\_\_  
Notary Public Signature

My commission expires: \_\_\_\_/\_\_\_\_/\_\_\_\_