MEDICAL RELEASE FOR VOLUNTEER SERVICE

International Ministries

It is very important that each volunteer be physically able to serve in their respective country of service, and to fully disclose any medical conditions so that the hosting partner/missionary can be prepared in the event of an emergency. This information will be kept confidential, held by International Ministries, and given only to the hosting facility.

Name:_____
Last First Middle

Address: _____

Phone #: _____ Date of Birth: _____

(Month / Day / Year)

Location of Volunteer Service: _____

Assignment (description of service): _____

1. **Any known disease or disability?** _____ **YES** _____ **NO**
   If yes, give details and explain how this might or might not affect your international assignment.

   _____

   _____

   _____

2. **Any regular medication needed?** _____ **YES** _____ **NO**
   If yes, complete the following...
   a) List medication(s), form (liquid, tablet, injection, etc.) and if refrigeration is needed.

   _____

   _____

   Please continue list on another sheet if necessary

   b) If you cannot take a large enough supply to last the duration of your international service, what provisions have you to get more?

   _____

   _____

3. **Please list any dietary restrictions you have:**

   _____

   _____

4. **Please list any allergies that you have – (ie, food, medicine, animal, environmental).**

   _____

   _____

PHYSICIAN'S STATEMENT

I am aware of this applicant's desire to serve in _____ and certify that to the best of my knowledge, the applicant's medical conditions have been fully disclosed. It is my opinion that this applicant is physically able to serve in _____ _____.

Physician's name (Print) _____

Physician's signature _____

Address _____ **Office Phone** _____

INSURANCE INFORMATION:

Insurance Company: _____ Policy or Group #: _____

Insurance Company Phone Number: _____

EMERGENCY CONTACT: In case of an emergency, who should be contacted on your behalf?

Name _____ Relationship to you _____ Phone _____

Email: _____

Name _____ Relationship to you _____ Phone _____

Email: _____

In the event of a medical emergency resulting in my (and my spouse, if accompanying me on the mission) being incapacitated and not competent to make responsible decisions concerning my medical treatment, I hereby authorize those responsible for overseeing the mission in which I am serving to take me to the nearest licensed physician, medical center or hospital, and to secure necessary treatment (medications, injections, anesthesia or surgery) to protect my well being. I will be responsible for all medical costs not covered by my insurance.

In the event of a medical emergency involving my spouse or my or our dependent who is accompanying me on the mission in which I am serving, which occurs while I (and, if applicable, my spouse) is incapacitated and not competent to make responsible decisions concerning the medical treatment of my spouse or any such dependent, I hereby authorize those responsible for overseeing the mission to take my spouse or dependent to the nearest licensed physician, medical center or hospital, and to secure necessary treatment (medications, injections, anesthesia or surgery) to protect the well being of my spouse or dependent. I will be responsible for all medical costs not covered by any applicable insurance.

Signature _____ **Date:** _____

Print Name: _____

This form should also be signed below by the volunteer's spouse, as well as any non-minor dependent, that is accompanying the volunteer on the mission.

Signature _____ **Date:** _____

Print Name: _____

Signature _____ **Date:** _____

Print Name: _____