



MISSION OF MERCY

One Child Matters

MEDICAL WAIVER & RELEASE FORM

PERMISSION TO TREAT FORM

Northern New England District Women's Ministry
Mission Trip to Dominican Republic
January 30th-February 7th, 2012 (tentative)

WAYS TO RESPOND:

Mail Send to:

Mission of Mercy
Attn: Keith Thompson
15475 Gleneagle Dr.
Colorado Springs, CO 80921

Before you complete the form, please know...

Travelers with disabilities

Laws for accommodating those with disabilities are vastly different than in the USA. Mission of Mercy cannot guarantee the level of physical demands for the trip or the assistance available to an individual. For that reason, we are unable to accommodate participants in wheelchairs or those unable to walk for extended periods of time.

Insurance Information

I understand that my personal health insurance will provide primary coverage for any accident, incident or event that occurs while I am a trip participant and further understand that Mission of Mercy will provide an international travel health insurance policy which provides secondary coverage to my health insurance.

Immunization

It is strongly recommended that you contact your physician to inquire about any pre-travel vaccinations he/she might suggest. It is the policy of Mission of Mercy to leave such decisions to the traveler and his/her chosen medical professional. You may also check the Center for Disease Control for information on country requirements (www.cdc.gov).

This form required for traveling in partnership with
Mission of Mercy

INFORMATION ON YOUR CURRENT HEALTH COVERAGE				
Insurance company Name	Policy number	Insurance ID number		
Company Address	City	State	Zip	
Phone ()	In whose name is the policy		Traveler Name	

CURRENT HEALTH CONDITION									
Pre-existing medical conditions:									
Do you have... <table style="margin-left: 20px; border: none;"> <tr> <td><input type="checkbox"/> Heart Condition</td> <td><input type="checkbox"/> Diabetes</td> </tr> <tr> <td><input type="checkbox"/> Epilepsy</td> <td><input type="checkbox"/> Nervous Disorder</td> </tr> <tr> <td><input type="checkbox"/> Asthma</td> <td><input type="checkbox"/> Frequent Upset stomach</td> </tr> <tr> <td><input type="checkbox"/> Physical Handicap</td> <td></td> </tr> </table>		<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Nervous Disorder	<input type="checkbox"/> Asthma	<input type="checkbox"/> Frequent Upset stomach	<input type="checkbox"/> Physical Handicap	
<input type="checkbox"/> Heart Condition	<input type="checkbox"/> Diabetes								
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Nervous Disorder								
<input type="checkbox"/> Asthma	<input type="checkbox"/> Frequent Upset stomach								
<input type="checkbox"/> Physical Handicap									
Name & dosage of any medications that must be taken during the trip:									
Date of Last Tetanus Shot:*									
Do you wear contact lenses?	<input type="checkbox"/> Yes <input type="checkbox"/> No								
Any known allergies:									
Allergies to medications:									
Details of treatment for allergic reactions:									
Activity restrictions:									
Should you require medical attention, please note any information that the physician should be aware of prior to your treatment:									
<input type="checkbox"/> Yes <input type="checkbox"/> No I understand and acknowledge that I am in good physical and mental health and am able to walk unassisted and lift a minimum of 20 pounds without assistance.									
*It is strongly recommended that you contact your physician to inquire about any pre-travel vaccinations he/she might suggest. It is the									

policy of Mission of Mercy to leave such decisions to the traveler and his/her chosen medical professional. You may also check the Center for Disease Control for information on country requirements (www.cdc.gov).

HIPAA ACKNOWLEDGEMENT

For purposes of compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy rules, all health care providers shall treat my acting health care agent as my Personal Representative. As required by 45 CFR 164.524, I hereby expressly authorize any physician, hospital and any other person or organization to release and disclose to my agent any information any of them may have concerning any treatment, diagnosis, recommendation, or other facts which they may have concerning my physical condition and any health care, counsel, treatment or assistance provided to me. My Personal Representative may authorize disclosure of my protected health information to others. Health care providers covered by HIPAA include, but are not limited to, the physician, health care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy, insurance company and health care clearing houses.

Initial Here: _____

AUTHORIZATION FOR MEDICAL TREATMENT

This health history is correct to the best of my knowledge and I am able to engage in all activities involved with this trip except as noted. I hereby give permission and authorize the licensed physician(s) selected by my Agent to secure or administer emergency medical treatment, including hospitalization and any other emergency medical procedures which may be needed by me.

I further authorize the physician(s) or licensed dentist(s) to associate any necessary medical providers at his/her discretion. I understand that this consent is given in advance of any specific diagnosis or treatment being required, but is given to encourage my Agent and said physician(s) or dentist(s) to exercise their best judgment regarding the requirements of such diagnosis or medical, dental or surgical treatment.

I agree to remain fully liable and responsible for the payment of any such hospital, physician, ambulance, dental or medical expenses with exception of the Accident Coverage as set forth below. I further agree that in giving this permission, authorization and consent, Mission of Mercy and Bethesda Ministries, Inc. do not assume any responsibility or liability for the payment of such hospital, physician, ambulance, dental or other medical expenses which may be incurred.

Initial Here: _____

This Section For Notary Use Only

The undersigned warrants that he/she has fully read and understands this **Medical Waiver & Release Permission to Treat** agreement and voluntarily signs the same, and that no oral representations, statements, or inducements apart from the foregoing written agreement have been made to the undersigned.

IN WITNESS WHEREOF, I have executed this document this ____ day of _____, 200____.

Printed Name of Participant: _____

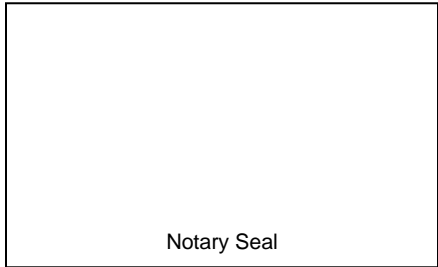
Signature of Participant: _____

Passport Number: _____

STATE OF _____ COUNTY OF _____

On this ____ day of _____, 200__, before me personally appeared _____ to me known to be the person described in and executed the foregoing instrument and acknowledged that _____ executed the same as _____ free act and deed.

IN WITNESS THEREOF, I have hereunto set my hand and affixed my official seal in the County of _____, State of _____, the day and year first above written.



Notary Public

My Commission Expires: _____