gl MISSION TRIPS

MEDICAL RELEASE & HEALTH FORM

LMNelms@Gospelink.org | Gospelink.org/TripsHQ | (434) 485-7007

This form needs to be completed by mission trip participants and returned to Gospelink within 30 days of the date of registration to receive travel approval.

It is very important that each trip participant 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 Gospelink and given only to the hosting facility. Once participants are 30 days of the scheduled departure, this form can no longer be accepted.

PERSONAL INFORMATION

TRIP PARTICIPANT'S LEGAL NAME | **DOB** *(mm/dd/yy)* | **GENDER**

EMERGENCY CONTACT | **CONTACT'S PHONE #**

2ND EMERGENCY CONTACT | **2ND CONTACT'S PHONE #**

INSURANCE & PHYSICIAN INFORMATION

PHYSICIAN | **OFFICE NUMBER**

OFFICE NAME | **OFFICE ADDRESS**

PERSONAL HEALTH INSURANCE COMPANY

NAME ON THE POLICY | **POLICY NUMBER**

Do you require the use of any medical device such as a c-pap machine on a regular basis? ☐ Yes ☐ No

If yes, please give wattage, prong type, cord length etc.:_____

ALLERGY INFORMATION

List any food, drug, or contact allergies? (Including, but not limited to penicillin, sulfa, iodine, aspirin, acetaminophen, poison ivy, bees, soaps or other contact substances, milk, peanuts or other food products):

ALLERGY: | **MEDICINE REQUIRED**

OFFICE USE ONLY | **TRIP INSURANCE COMPANY** | **POLICY**

MEDICAL INFORMATION

Do you have any know **disease or disability?** ☐ **Yes** ☐ **No**

If Yes, please provide details and explain how this might or might not affect your abilities to travel or participate in the mission trip activities or work assignments.

Do you have any regular **medication needed?** ☐ **Yes** ☐ **No**

If Yes, please list any medications, herbs or supplements you are presently taking or will be taking during your trip including dosage, frequency, form (liquid, tablet, injection, etc), and if refrigeration is required. **Please continue on to an additional sheet if necessary.**

CONDITION	MEDICATION	DOSAGE	FREQUENCY	FORM	REFRIG. NEEDED
					☐
					☐
					☐
					☐
					☐

Note: To bring certain drugs into some countries may require special clearance. Also, drugs may not be available to purchase in all countries

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

DIETARY RESTRICTIONS

Do you have any **dietary restrictions?** ☐ **Yes** ☐ **No**

If Yes, please provide details and explain how this might or might not affect your international assignment.

PHYSICIAN'S APPROVAL FOR TRAVEL

Physician's approval is recommended for all trip participants, but may be required for some trip participants upon request from the Gospelink Travel Director

I am aware of **APPLICANT'S FULL NAME** _____ desire to serve in _____ and certify that to the best of my knowledge, the applicant's medical conditions on the second page contains a complete disclosure of conditions. It is my opinion that this applicant's is physically able to serve.

PHYSICIAN'S SIGNATURE **DATE**

MEDICAL RELEASE

In the event of a medical emergency resulting in **me and my accompanying spouse (if applicable)** 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 accompanying spouse or my accompanying dependent, 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 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 cost not covered by any applicable insurance.

PARTICIPANT'S SIGNATURE **DATE**

For Trip participants under the age of 18, you must have a parent or legal guardians signature.

SIGNATURE OF MINOR'S PARENT/LEGAL GUARDIAN **DATE**

For married travelers or those traveling with a non-minor dependent: This form should also be signed below by the participant's spouse/non-minor dependent that will be accompanying the volunteer on the trip.

PARTICIPANT'S SPOUSE SIGNATURE **DATE**

NON-MINOR'S SIGNATURE **DATE**

Save a copy & send your completed form:
LMNelms@Gospelink.org | Gospelink, PO Box 1160, Forest, VA 24551

OFFICE USE ONLY	RECEIVED	SUBMITTED TO GL STAFF