EXPIRES 12.31.2028

Capstone Church Medical Release/Permission to Treat Form

Name:_____ Gender:_____ SSN: _____ DOB:_____ Age:_____
Complete Address:_____ City:_____ST:_____ Zip:_____
Home Phone:_____ Cell Phone:_____Email_____
Parent/Guardian (if younger than 19 yrs. old):_____

Provide the name/contact information. of 2 individuals NOT traveling with you who may be contacted in the event of an emergency.

Name_____ Name_____
Relationship to you_____ Relationship to you_____
Phone_____ Phone_____
Alt. Phone_____ Alt. Phone _____

Insurance Co. _____ Policy Holder_____
Relationship_____ Policy #_____ Group # _____
Insurance Co. Address_____ Phone # _____

Primary Care Physician_____ Phone_____
Physician Address_____
Do you have any allergies? ____Yes _____no If yes, explain_____
Have you been in contact with contagious/infections diseases within the last four weeks? _____Yes _____No If yes, explain:
_____
Do you have any special dietary restrictions? _____Yes _____No If yes, explain:
_____
List any specific medical conditions requiring medical treatment and/or medication:
_____
List all operations/serious injuries within the past five years:_____
_____
List all medication taken on a regular basis:_____
_____
What type of pain medication may be given if necessary?_____

I hereby give permission to medical personnel selected by my team member or his/her designee (hereafter the Authorized Agent) to order x-rays, routine tests, and treatment for me. In the event of an emergency and neither my primary nor secondary contact can be reached, I hereby give permission to the physician selected by the Authorized Agent to secure proper treatment, hospitalize, order injections and/or anesthesia, and/or authorize surgery for me. I further authorize the release of the above medical information to appropriate medical personnel and/or the health coverage insurance company. In addition, I have, and do hereby, release Capstone Church, its employees or agents, and in-country contacts from liability associated with participation in a mission trip. I understand that if I do not have medical insurance, I will be responsible for any medical expenses in the event of a sickness or injury. I understand that there are risks involved in participating in a mission trip.

Signature:_____ Date:_____
(Must be signed by a parent or guardian if under 19 years of age.)

The following is to be completed by the Notary Public witnessing the individual's signature.

The State of _____ the County of _____ Before me, a Notary Public, on this day personally appeared_____ known to me (or proved to me on the oath of _____) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purpose and consideration therein expressed. Given under my hand and the seal of the office this _____day of_____, A.D. _____.

Notary Public Signature_____
My commission expires the_____ day of_____, A.D._____.

**** If any of your information changes before 12.31.2028, you need to fill out a new form with updated information.****

EXPIRES 12.31.2028

Capstone Church Release of Liability | aʟ{{ʟhb ¢wʟt

In signing this form, I,_____, agree not to hold Capstone Church, her officers, employees, or other agents liable for any injury, loss, damage, or accident that I might encounter ØKʎfŜ ŁJł·ŃŮŮÕŁJł·ŮŮyƎ ʎyʃł· missions event/effort.

I realize and acknowledge that my participation on a mission trip, either foreign or domestic, includes risk and possible dangers. I am well aware that my travel to a foreign country exposes me to such risks as accidents, disease, war, political unrest, injury from construction projects, and other calamities.

I hereby assume any such risks that might result from my participation in a mission project/trip, and I unconditionally agree to hold Capstone Church, its officers, employees, or other agents blameless for any liability concerning my personal health and well-being, or any liability for my personal property that might be lost, damaged, or stolen while on any mission endeavor. I also understand that I am responsible for obtaining and paying for any immunizations that I do not currently have that are required/recommended by the CDC (or other pertinent officials) to any destination involved.

Signed:_____

Parent's Signature (if under 19 years of age):_____

Dated this_____ day of_____, 20_____.

The following is to be completed by the Notary Public witnessing the individual's signature.

The State of _____ the County of _____ Before me, a Notary Public, on this day personally appeared_____ known to me (or proved to me on the oath of _____) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purpose and consideration therein expressed. Given under my hand and the seal of the office this _____day of_____, A.D. _____.

Notary Public Signature_____

My commission expires the_____ day of_____, A.D._____.

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