Idlewild Adult Medical Release

For Completion by all participants age 18 or older

Name:_______________________________ Emergency Contact:_______________________________

Relationship:_________________________ Phone(s):_______________________________________

Insurance Information

Company:____ Policy type:_____________________

Phone: ______________________________________ Policy #:_________________________________

Project (other than U.S.) participants **must have insurance coverage outside the U.S.**

Medical Information

List all prescription medication(s) you will bring on the project: ________________________________

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For what condition (s)?____

Date of last tetanus shot (this must be within ten years):_______________________________________

Date of Hepatitis A inoculation (this is **not** required, but recommended):__________________________

List any physical disabilities or limitations:____

List any known allergies and reactions:____

List any major illnesses in the past year:____

Have you fainted or passed out? _________When? ___________Why?_________________________

Do you have any eating disorders? ________ If yes, have you ever received counseling? _____________

For Completion by Physician

(If you are under the care of a physician for any condition or prescription medication, have him/her complete the following):

I have examined _____________________and find him/her to be in good general health and physically able to take part in the mission trip to _____________________ on (date)___________to___________.

Doctor's signature :______________________________________Date:_________________________

Release

In case of unconsciousness, or inability to release myself for medical treatment resulting from any illness, injury, or accident requiring medical attention, I give my permission to Idlewild Baptist Church, its agents, officers, volunteers, directors, employees and affiliates (collectively "Idlewild") as well as all attending health care professionals (defined as including, but not limited to registered nurses, licensed practicing nurses, physicians 'assistants, doctors and paramedics) to provide medical treatment, to hospitalize, anesthetize, or perform surgery on me as is required. I, the undersigned, do release and discharge from, and covenant not to sue, Idlewild for any and all actions, damages or claims arising out of the treatment of any illness, injury, or loss incurred during participation on the trip even if any such illness, injury or accident is caused by the negligence of Idlewild or any attending health care personnel.

***Participant Signature**: _______________________________________Date: ______________________*

State of________________________, County of____________________. Sworn to and subscribed to me this _____day of _______________, 20_____.

Notary Public signature: __________________________________My commission expires:___________

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