MISSIONS

Medical Release Form 2019

The undersigned hereby authorizes and consents to any medical care, treatment or procedure, including doctor, hospital, and related services, as may be deemed necessary for the participant by an authorized representative of the Church if the participant is incapacitated and unable to make and communicate a health care decision. The undersigned acknowledges that this authorization and consent is given in advance of any specific injury or illness, and is given to enable the Church's authorized representative to exercise his or her best judgment as to any diagnosis or treatment which may be required. The Church and its Representatives, including any authorized representative of the Church, shall not have any liability or responsibility for any mistake or error in judgment made in good faith in approving any care, treatment or procedure for the undersigned. This authorization and consent shall remain in effect from January 1, 2019 through February 28th, 2020 unless sooner revoked in writing by the undersigned. Third persons (including doctors, hospitals and other health care providers) may nevertheless rely upon the certification of any authorized representation of the Church as to the current effectiveness of the authority and consent provided hereunder. Furthermore, the undersigned hereby releases any health care provider who provides any medical care, treatment or procedure to the undersigned in reliance on this instrument, from any and all claims, suits, or liabilities arising out of or with respect to said care, treatment or procedure.

IN FURTHERANCE THEREOF, the undersigned has executed this instrument as his/her free act and deed.

Participant's Signature: _____

Father's Signature: _____ **Mobile Phone:** _____
(if under 18 yrs old)

Mother's Signature: _____ **Mobile Phone:** _____
(if under 18 yrs old)

Emergency Contacts

1) Name: _____ **Relationship:** _____

Home Phone: _____ **Mobile Phone:** _____

2) Name: _____ **Relationship:** _____

Home Phone: _____ **Mobile Phone:** _____

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PERSONAL INFORMATION

Name: _____ **Date of Birth:** _____ ☐ **male** ☐ **female**

Address: _____ **City, ST:** _____ **Zip:** _____

Home Phone: _____ **Cell Phone:** _____

E-mail: _____

MEDICAL BACKGROUND INFORMATION

Doctor's Name: _____ **Phone:** _____

Medical Insurance: _____ **Policy #:** _____

Date Last Tetanus Shot: _____ **Hep A:** _____ **Hep B:** _____

Medical Disorders, Medications & Instructions: _____

_____

Food/Medical Allergies: _____

Other: _____

*Please include a copy (front and back) of your **current** health insurance card. Contact Tara Reimann at tareimann@stjstl.net or 636.779.2345 if this information changes.*

**for information on any vaccinations needed in the city/country you are going please see the CDC website: https://wwwnc.cdc.gov/travel/destinations/list/*