

# 3MT MEDICAL RELEASE FORM

PLEASE PRINT OR USE ELECTRONIC FORM	NAME (FIRST, MI, LAST)			CHURCH
	STREET ADDRESS			
	CITY	STATE	ZIP CODE	DATE OF BIRTH (mm/dd/yyyy)
	INSURANCE COMPANY		INSURANCE/POLICY #	
EMERGENCY CONTACT	NAME (FIRST, MI, LAST)			RELATIONSHIP
	PHONE NUMBER	WORK PHONE NUMBER		CELL PHONE NUMBER
PREVIOUS MEDICAL HISTORY	PLEASE CHECK ALL THAT APPLY <input type="checkbox"/> ASTHMA <input type="checkbox"/> DIZZINESS <input type="checkbox"/> KIDNEY TROUBLE <input type="checkbox"/> OTHER: _____ <input type="checkbox"/> DIABETES <input type="checkbox"/> HAY FEVER <input type="checkbox"/> STOMACH UPSET <input type="checkbox"/> OTHER: _____ <input type="checkbox"/> SINUSITIS <input type="checkbox"/> BRONCHITIS <input type="checkbox"/> HEART PROBLEMS <input type="checkbox"/> OTHER: _____			
	<b>VACCINATIONS   Date</b> <input type="checkbox"/> CHICKEN POX _____ <input type="checkbox"/> MMR _____ <input type="checkbox"/> TETANUS _____			
	PREVIOUS ILLNESS/OPERATIONS			
	LIST ALL MEDICATIONS			
ALLERGIES - PLEASE LIST ALL	FOOD			
	DRUG			
	INSECT BITES			
	SPECIAL DIET			
	OTHER			
PERMISSION FOR MEDICAL TREATMENT	MY PERMISSION IS GRANTED TO THE YOUTH DIRECTOR OR ANY PERSON IN CHARGE OF MID-MISSOURI MISSION TEAM TO OBTAIN MEDICAL TREATMENT IN CASE OF SICKNESS OR INJURY TO MY CHILD OR MYSELF (NAME) _____ WHILE PARTICIPATING IN THIS MISSION TRIP. I, _____ THE UNDERSIGNED DO HEREBY VERIFY THAT THE ABOVE INFORMATION IS TRUE TO THE BEST OF MY KNOWLEDGE AND I DO HERE BY RELEASE AND FOREVER DISCHARGE ALL SPONSORS, THE PARTICIPATING CHURCHES AND THE MID-MISSOURI MISSION TEAM FROM ANY AND ALL CLAIMS, DEMANDS, ACTIONS OR CAUSE OF ACTION, PAST, PRESENT OR FUTURE ARISING OUT OF ANY DAMAGE OR INJURY WHILE PARTICIPATING IN ACTIVITIES OF MID-MISSOURI MISSION TEAM (3MT).			
	SIGNATURE OF PARENT / GUARDIAN / PARTICIPANT			DATE
_____ PERSONALLY APPEARED BEFORE ME AND PERSONALLY KNOWN BY ME, EXECUTED THE FOREGOING PERMISSION AND RELEASE FORM. WITNESS MY HAND AND OFFICIAL SEAL, DATED THIS _____ DAY OF _____ YEAR _____ STATE OF _____ COUNTY OF _____.				
SIGNATURE NOTARY PUBLIC			SEAL	
MY COMMISSION EXPIRES (mm/dd/yyyy)				
PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD AND POLICY NUMBER ALONG WITH THIS FORM AT REGISTRATION. YOU MAY NOT PARTICIPATE WITHOUT THIS FORM PROPERLY COMPLETED AND NOTARIZED.				
IF OVER 18 PLEASE PROVIDE YOUR EMAIL ADDRESS A LINK FOR THE BACKGROUND CHECK WILL BE EMAILED TO YOU			EMAIL	