Name of Participant		Date of Birth		
Address	City	State	ZIP	
PERMISSION				
<ul> <li>I do hereby verify that the below inforchurch to obtain medical attention in</li> <li>I hereby grant permission for deemed necessary by the chur and sound decisions for mysel</li> <li>I also hereby release, absolve, church, the organizers, sponso actions or cause of actions, paraticipating on this trip.</li> <li>I assume all risks and hazards to and from the area. In case organizers, the sponsors, or ar responsibility any person trans</li> <li>I agree to provide medical ins</li> </ul>	case of sickness or injury. an attending physician or horch for my welfare should I of the form the fo	ospital to perfor be unable to ma and forever disc by and all claims out of injury of the activities a tive all claims ag them. I likewise	m whatever care ke reasonable harge the demands, damage while and transportation rainst the	
		/		
Signature of Participant		Date		
MEDICAL AND INSURANCE IN	FORMATION			
Family Insurance	Poli	icy #		
Family Physician	Pho	ne #		
Check applicable box and give approp o None o Allergies o Asthma	priate information regarding	g any health con	ditions below:	
<ul><li>o Diabetes</li><li>o Dizziness</li></ul>				
o Heart Trouble				
o Others				

Immunizations: (Non mandatory for Nor	th American Miss	sions)	
MMR: Date Received			
Typhoid Date Received			
Tetanus: Date Received			
Hepatitis A: Date Received			
Hepatitis B: Date Received	<del>_</del>		
Yellow Fever: Date Received			
Malaria: Date Received			
EMERGENCY NOTIFICATION			
Mother's Name		Phone	
Address	City	Sta	ateZip
Email Address			
Father's Name	D	hone	
Address			
			r

Email Address

If any above are checked yes, explain please: