

El Ayudante, Inc. Mission Team

MEDICAL INFORMATION AND RELEASE FORM

Team Leader _____

Date of Mission Trip _____

Team Member _____

Work Phone _____

Address _____

Home Phone _____

Birth Date _____

I, _____, will be traveling to Nicaragua to minister with El Ayudante, Inc. to the people in and around Leon. If I need medical attention, I give my team members and the El Ayudante staff the right to give consent to authorize emergency medical care. It is intended that this document be presented to the physician or appropriate hospital or medical representative at such times as the medical care shall be authorized. It is intended that the authorization release the physician, dentist, person rendering such care at the hospital or institution in which such care is given, El Ayudante, Inc., and my team members from any liability resulting from the failure of me signing a consent or authorization to render such care. It is the intent that El Ayudante's staff and team members shall act in my stead in making such decisions.

I have put the important medical facts, if any, on this form. The medical facts are intended to help the doctor in deciding what treatment is to be given, but are in no way intended to restrict the giving of authorization or consent by El Ayudante's staff or team members. I understand that this form is in effect from the departure of our team to our arrival back to our city of departure.

MEDICAL HISTORY INFORMATION:

1. Do you have any physical limitations or emotional disorders? Please explain.
2. Do you have any medical problems? If so, list them.
3. Have you had major surgery in the past 12 months? If so, explain.
4. Are you presently taking any prescription or non-prescription medicine on a regular basis? If so, list.

5. Are you allergic to any medication or food? If so, list. Are there special medications, dosages, and instructions for this allergy? If you are allergic to a food, please make the staff aware of this upon your arrival—or before if needed.

Date of last Tetanus _____
Participant's Physician _____ Phone _____
Medical Insurance Provider _____ Phone _____
Policy Number _____ Group Number _____

Who should be contacted in case of emergency?

Name _____ Home Phone _____
Work Phone _____ Cell Phone _____

Signature of team member _____ Date _____

Signature of parent _____ Date _____

(if youth under 18)

Notarization of Medical Release Form

Attention Notary Public: You are notarizing the signature of the parent if this team member is under the age of 18.

State of _____ County of _____

On this _____ day of _____, _____, before me personally appeared

_____ personally known to me (or providing the following

identification) _____ and who executed the within

instrument, and who acknowledged the same to be the free act and deed thereof.

Notary signature

My commission expires _____