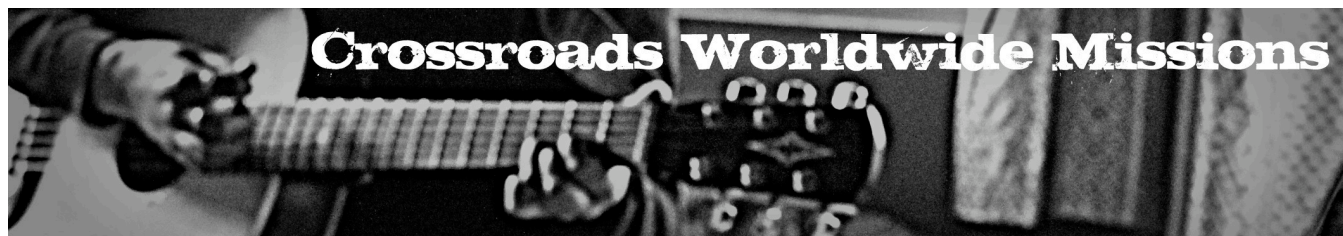


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CONSENT FOR MEDICAL TREATMENT; RELEASE AND HOLD-HARMLESS FOR TRAVEL

Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

WHEREAS, (My child/I) \_\_\_\_\_ wishes to be a member of Crossroads Worldwide Mission Team which will be traveling and staying in \_\_\_\_\_, and whereas, certain circumstances may occur resulting in (my child's/my) need for medical/dental care and treatment, and further resulting in my inability to give consent for such care and treatment; THEREFORE, in consideration of permission from Crossroads Worldwide for (my child/myself) to participate in said missionary group.

I, \_\_\_\_\_, being of legal age, authorize Crossroads Worldwide or any designated agent of Crossroads Worldwide/Clayton King Ministries, to act on (my child's/my) behalf should I be unable to do so and to consent to all medical/dental care and treatment, including but not limited to diagnostic test, x-ray examination, anesthesia, surgery, or other procedures which Crossroads Worldwide deems necessary for (my child's/my) medical well being for the duration of the mission trip. This consent is given in advance of any special diagnosis, treatment, surgery, or hospital care required and to the administration of any over the counter medications including but not limited to Tylenol, Advil, allergy medications, and is given to provide authorization and specific consent for medical/dental treatment and care in (my child's/my) behalf. Any consent by Crossroads Worldwide shall have the same force and effect as if I had personally given the consent.

I certify I have personal health insurance, which will provide coverage for (my child/me) during the duration of said mission trip. I understand that Crossroads Worldwide provides the opportunity for optional travel insurance, but provides no health plan and it is my responsibility to seek coverage for myself/my child.

Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Company Phone # (\_\_\_\_) \_\_\_\_\_

I hereby release Crossroads Worldwide, its agents, servants, employees and assigns for any and all damages, liability or costs resulting from the authorizing of medical treatment on (my child/my) behalf under the terms of the consent. I further hold Crossroads Worldwide harmless and agree to indemnify Crossroads Worldwide for any and all costs, damages or expenses incurred by Crossroads Worldwide as a result of any claim or action filed by any part alleging damages incurred and as result of any medical treatment provided or authorization for treatment provided. I understand that this release and indemnification releases treatment for the conduct of Crossroads Worldwide and it agents, servants, employees or assigns even if such conduct is negligent.

Childhood Immunizations (These must be up to date, please do not leave blank.)

YES	NO	TYPE	Year Administered
___	___	Mumps/Measles/Rubella	_____
___	___	Diphtheria/Pertussis/Tetanus	_____
___	___	Polio	_____
___	___	Tetanus (within 10 yrs.)	_____
___	___	Hepatitis A and B	_____

Please complete the following questions:

- Are you currently taking any prescription medication? Yes \_\_\_ No \_\_\_
- If Yes please specify the medication(s) and the dosage \_\_\_\_\_
- Are you currently using any non-prescription drugs on a regular basis? Yes \_\_\_ No \_\_\_
- If Yes please specify the medication(s) and the dosage \_\_\_\_\_
- Have you ever-received treatment or counseling for alcohol or chemical abuse? Yes \_\_\_ No \_\_\_
- If Yes, please specify when and where \_\_\_\_\_
- Are you presently under a physician's care for any illness? Yes \_\_\_ No \_\_\_
- If yes, please explain \_\_\_\_\_
- What was the date and who was the Physician of your last physical exam?

## Medical Release Continued: Please Print this page and fax/mail to our

Please list all surgical operations or hospitalizations you have undergone:

1. Operation/Illness \_\_\_\_\_  
 Reason \_\_\_\_\_ Date \_\_\_\_\_  
 Name and Address of Hospital \_\_\_\_\_  
 Name of Physician \_\_\_\_\_  
 Remaining Effects \_\_\_\_\_

2. Operation/Illness \_\_\_\_\_  
 Reason \_\_\_\_\_ Date \_\_\_\_\_  
 Name and Address of Hospital \_\_\_\_\_  
 Name of Physician \_\_\_\_\_  
 Remaining Effects \_\_\_\_\_

**Please list any special health concerns INCLUDING FOOD OR DRUG ALLERGIES:**

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**Have you ever been treated by a doctor for any of the following? Every item must be checked.**

YES	NO		YES	NO	
___	___	Asthma or Chronic wheezing	___	___	Mental Health counseling
___	___	Any other respiratory problems	___	___	Fainting spells
___	___	Cysts or Tumors of any kind	___	___	Convulsions, epilepsy or seizures
___	___	Chronic persistent cough	___	___	Parkinson's Disease
___	___	Skin disorder other than acne	___	___	Anemia or other blood disorder
___	___	Goiter	___	___	Serious bodily injury
___	___	Diabetes or Hypoglycemia (low blood sugar)	___	___	Thyroid ailment
___	___	Circulatory trouble	___	___	Severe allergic reaction
___	___	Cancer	___	___	Aids Virus or HIV
___	___	Hearing or vision impairment	___	___	Persistent recurring indigestion
___	___	Intestinal or Bowel problems	___	___	Stomach or duodenal ulcers
___	___	Kidney Problems	___	___	High or low metabolism
___	___	Tuberculosis	___	___	Gal bladder stones or colic
___	___	Rheumatism, arthritis, painful swollen joints	___	___	Prostate problems
___	___	Chronic back pain injury or scoliosis etc.	___	___	Breast/Menstrual Disorder
___	___	High Blood pressure/ any cardiac problems			

**\*\* Please Note-** If you checked "NO" to all the questions above you are not required to complete a doctor's release form. **If you checked "YES" to any of the questions on this form you are required to:**

1. Visit with your Doctor
2. Have him or her complete and sign a Doctor's release form.

**\*\*YOUR ACCEPTANCE WILL BECOME VOID IF THESE STEPS ARE NOT FOLLOWED.**

I further authorize for (my child's/my) Crossroads Worldwide to release and all other medical information or records necessary to any party deemed necessary by Crossroads Worldwide, its agents, servants, employees and assigns for the providing of medical treatments to (my child, myself) or to members of the missionary group to insure proper placement of (my child/myself) in such groups. I am aware that serious illness or injury may occur on a mission trip and that such illness and injury may result in (my child/myself) incurring costs, expenses and damages for which I am solely responsible including, but not limited to, return of (my child/myself) by air ambulance at a cost of \$10,000 or more. I am aware that serious illness requiring return by air ambulance could cost more than \$10,000. I agree that I am solely responsible for any expenses that may arise from (my child's/my) return by air ambulance or other extraordinary means. I hereby release and hold harmless Crossroads Worldwide, its officers, employees, and representatives/volunteers from all liability for personal injury, including death as well as property damage or loss arising out of (my child's/my) participation in this trip. I have read and understand the information above. The information I have given Crossroads Worldwide is accurate and true to the best of my knowledge. My enclosed signature insures that all information on these forms is completely true and has not been altered in any way.

Medical Release Continued: Please Print this page and fax/mail to our

If you are in the legal custody of both parents-both signatures are required

If you are in the legal custody of one parent- the signature of the one who has legal custody is required and a copy of a legal document evidencing the custody agreement, or a notarized copy of a death certificate for a deceased parent. We apologize for any inconvenience.

Father's Signature \_\_\_\_\_ Date \_\_\_\_\_

(IF APPLICANT IS UNDER 18)

Mother's Signature \_\_\_\_\_ Date \_\_\_\_\_

(IF APPLICANT IS UNDER 18)

Guardians Signature \_\_\_\_\_ Date \_\_\_\_\_

(IF APPLICANT IS UNDER 18)

Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

The Following is for Doctor's Use Only. This is only for those who checked "NO" to any of the questions on the previous page.

DOCTOR'S RELEASE FORM

Complete this form if you checked "yes" to any of the questions on the medical checklist.

In the past Crossroads Worldwide has had people who have experienced difficulty completing the daily mission activities. The missionary may be involved in challenging and extended periods of walking and hiking at different altitudes as part of the daily itinerary. Dietary and climate changes also add to the physical intensity of our trips. Please be considerate of these factors.

Doctors Name: \_\_\_\_\_ Applicants Name: \_\_\_\_\_
Address: \_\_\_\_\_ Address: \_\_\_\_\_
Office Phone: \_\_\_\_\_ Phone: \_\_\_\_\_
Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_\_

I have reviewed the MEDICAL INFORMATION, CHECKLIST FORM, and MEDICAL HISTORY, and I have performed a physical exam.

(Please check appropriate choice)

- I find him/her to be in adequate condition for international travel and participation in all the activities of this trip.
I have prescribed a medical plan of action for him/her to meet prior to the mission trip in order to participate in the daily itinerary during the trip.
I do not recommend that this person participate at this time.

Physician's Signature \_\_\_\_\_ Date \_\_\_\_\_

Dear Physician:

If you prefer, this form may be faxed to:
(704) 434-2919

Or may be mailed to:
Crossroads Worldwide
Attn: Missions Applications
307-A E. College Ave.
Shelby, NC 28152

If you have any questions, please call:
(704) 434-2920