

# 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 and/or Matagalpa. 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?

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 \_\_\_\_\_.