Trip Application / Medical Release / Permission to Treat Form

Team Information

Team Leader: _____

Trip Location: _____ Trip Dates: _____

Personal Information

Full Name: _____ Gender: _____

SSN: _____ DOB: _____ Age: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Parent/Guardian (if younger than 19 years old): _____

Do you have any special skills or training specific to working with children or in the medical field? _____

_____

_____

Emergency Contact Information
Please provide the name and contact information of two individuals not traveling with your team who may be contacted in the event of an emergency.

Name: _____

Relationship to You: _____

Phone: _____ Alt. Phone: _____

Name: _____

Relationship to You: _____

Phone: _____ Alt. Phone: _____

Insurance Information
Please attach a copy of the front and back of your insurance card.

Insurance Company: _____

Policy Holder: _____ Relationship: _____

Policy #: _____ Group #: _____

Ins. Co. Address: _____ Phone: _____

Name of Travel Insurance Beneficiary: _____

Medical Information

Primary Care Physician: _____

Physician Address: _____ Phone: _____

Do you have any allergies? _____ yes _____ no

If yes, please explain: _____

_____

List any specific medical conditions requiring medical treatment and/or medication: _____

_____

_____

_____

List ALL medication taken on a regular basis: _____

_____

_____

List all operations/serious injuries (include dates) within the past five years: _____

_____

_____

Have you had contact with contagious or infectious diseases within the last four weeks? _____ yes _____ no

If yes, please explain: _____

_____

If this is your first trip with Westwood please give a brief testimony. _____

_____

_____

_____

_____

_____

_____

_____

Emergency Authorization

I hereby give permission to medical personnel selected by my team leader or his/her designee (hereafter the Authorized Agent) to order X-rays, routine tests, and treatment for me. In the event of an emergency and neither my primary nor secondary contact can be reached, I hereby give permission to the physician selected by the Authorized Agent to secure proper treatment, hospitalize, order injections and/or anesthesia, and/or authorize surgery for me.

I further authorize the release of the above medical information to appropriate medical personnel and/or the health coverage insurance company. In addition, I have, and do hereby, release WBC, its employees or agents, and in country contacts from liability associated with participation in a mission trip. I understand that if I do not have medical insurance, I will be responsible for any medical expenses in the event of a sickness or injury.

I understand that there are risks involved in participating in a mission trip.

Signature: _____ Date: _____

(Must be signed by a parent or guardian if under 19 years of age.)

The following is to be completed by the Notary Public witnessing the individual's signature.

The State of _____ the County of _____

Before me, a Notary Public, on this day personally appeared _____

known to me (or proved to me on the oath of _____) to be the person whose name is subscribed to the foregoing instrument and acknowledged to me that he executed the same for the purpose and consideration therein expressed. Given under my hand and the seal of the office this _____ day of _____, A.D. _____.

Notary Public Signature _____

My commission expires the _____ day of _____, A.D. ____