

# VALLEYDALE CHURCH MISSION TRIPS – For Adults

## GENERAL INFORMATION AND HEALTH HISTORY

Today's date: \_\_\_\_\_ Trip: \_\_\_\_\_

### PERSONAL INFORMATION

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Home: \_\_\_\_\_ Business: \_\_\_\_\_ Cell: \_\_\_\_\_

Email: \_\_\_\_\_ @ \_\_\_\_\_ . \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Home: \_\_\_\_\_ Cell: \_\_\_\_\_

Mission Trip Insurance Beneficiary: \_\_\_\_\_ Relationship: \_\_\_\_\_

### LIFESTYLE

Do you smoke?                      NO                      YES

If yes, how many packs/day? \_\_\_\_\_

For how long? \_\_\_\_\_

Do you exercise?                      NO                      YES

Type of Exercise? \_\_\_\_\_

How often? \_\_\_\_\_

Do you have any restrictions due to physical or health problems? \_\_\_\_\_

Please list any dietary restrictions: \_\_\_\_\_

### IMMUNIZATIONS (for informational purposes only - these are not necessarily recommendations)

Tetanus                                      NO                                      YES                                      Year: \_\_\_\_\_  
(required – must be w/in past 10 years)

Hepatitis A                                      NO                                      YES                                      Year: \_\_\_\_\_

Hepatitis B                                      NO                                      YES                                      Year: \_\_\_\_\_

TB Screening                                      NO                                      YES                                      Year: \_\_\_\_\_

Influenza (Flu) Shot                                      NO                                      YES                                      Date: \_\_\_\_\_

### HEALTH HISTORY

You may be serving in an environment that has limited health care resources. In order to provide for your health care needs and assure your medical safety, your team leader will bring your completed health form on the trip to use as a reference should you require medical attention. Please provide your honest answers to the following questions. The information you provide will be kept confidential. Please use the back of the form to expand on any answer you need to.

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Have you ever been hospitalized?                      NO                      YES  
 Year(s) \_\_\_\_\_  
 Reason(s) \_\_\_\_\_  
 Blood Type: \_\_\_\_\_

**Do you have, or have you ever had, any of the following:**

*Comments:*

Allergies to food, medicine or other substances.	NO	YES
Back problems, back pain or ruptured disk(s).	NO	YES
Any broken bones.	NO	YES
Cancer or tumors.	NO	YES
Shortness of breath or asthma.	NO	YES
Diabetes.	NO	YES
Ear or hearing problems.	NO	YES
Epilepsy or seizure disorder.	NO	YES
Thyroid problems or goiter.	NO	YES
Any heart disease.	NO	YES
High blood pressure.	NO	YES
Stroke(s).	NO	YES
Hernia.	NO	YES
Arthritis or joint problems.	NO	YES
Kidney disease or frequent urinary tract infections.	NO	YES
Stomach trouble or ulcers.	NO	YES
Migraine headaches.	NO	YES
Immune system disorders.	NO	YES
Are you now pregnant?	NO	YES

Please list any other significant illnesses or diseases not listed above? \_\_\_\_\_  
 \_\_\_\_\_

Reactions to allergies: \_\_\_\_\_

Has an allergic reaction ever required emergency room care?    No    Yes

If yes, please provide details: \_\_\_\_\_  
 \_\_\_\_\_

Please list any medications you are currently using and the condition being treated: \_\_\_\_\_  
 \_\_\_\_\_

Who is your primary physician? \_\_\_\_\_

Phone number: \_\_\_\_\_

Health Insurance Company: \_\_\_\_\_ Policy Number: \_\_\_\_\_

I hereby authorize the release of the information contained in this form to Valleydale Baptist Church and to the other ministries or organizations as necessary during this trip.

**Dated:** \_\_\_\_\_

**Signed:** \_\_\_\_\_

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## GENERAL RELEASE AND HOLD HARMLESS AGREEMENT

I, \_\_\_\_\_, desire to participate in various mission trips, programs, events or activities (hereinafter collectively referred to as the “Activities”) operated or sponsored by Valleydale Baptist Church (hereinafter referred to as the “Church”).

I understand and acknowledge that the Church will not allow me to participate in the Activities without releasing and holding the Church harmless from any liability arising out of my participation in the Activities. I have investigated the risks involved in my participation in the Activities and fully understand and assume such risks. Specifically, I understand and acknowledge that I may suffer or experience, among other things, personal injury or bodily damage, medical disabilities, loss or theft of personal property, imprisonment, abduction and even death.

I request that the church allow me to participate in the activities, and in consideration thereof agree hereby to release and forever discharge the church, its officers and directors, and its employees, agents, and any parties volunteering on behalf of the church, from all actions, causes of action, injuries, claims, damages, costs or expenses of any kind growing out of or related to any such activities in which I participate. I understand that this is a full and complete release of all injuries and damages, which I may sustain as a result of my participation in any activities, regardless of the specific cause thereof.

This agreement is binding on my heirs, successors, and personal representatives.

Dated: \_\_\_\_\_ Signed: \_\_\_\_\_

### *Medical Treatment Authorization and Power of Attorney*

In the event I suffer an injury or condition during my participation in the Activities, including transportation to and from the Activities, which may endanger my life, cause disfigurement, physical impairment, or undue discomfort if medical treatment is delayed, and as the result of which I am unable,

in the opinion of \_\_\_\_\_ (team leader), to make an informed decision regarding

such treatment, I hereby appoint \_\_\_\_\_ (team leader) my agent to act for me and in my name (in any way I could act in person) to make any and all decisions for me concerning my personal care, medical treatment, hospitalization and health care. This power of attorney shall terminate when, in the opinion of my attending physician, I am competent to make informed decisions regarding the need for medical treatment.

Dated: \_\_\_\_\_ Signed: \_\_\_\_\_

Dated: \_\_\_\_\_ Agent (Team Leader): \_\_\_\_\_

Dated: \_\_\_\_\_ Witness: \_\_\_\_\_