

# VALLEYDALE CHURCH MISSION TRIPS – For Minor

## GENERAL INFORMATION AND HEALTH HISTORY

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

### PERSONAL INFORMATION

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

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

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

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

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

**Father:** \_\_\_\_\_

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

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

**Mother:** \_\_\_\_\_

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

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

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

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

**Appointed Trip Guardian (Adult):** \_\_\_\_\_

### 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) 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

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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.

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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## MINOR GENERAL RELEASE AND HOLD HARMLESS AGREEMENT

I, \_\_\_\_\_, am the parent or legal guardian of \_\_\_\_\_ (the “minor”), who desires 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 the minor 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 the minor’s participation in the Activities and fully understand and assume such risks on his or her behalf. Specifically, I understand and acknowledge that the minor 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 the minor 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 the minor participates. I understand that this is a full and complete release of all injuries and damages which I or the minor may sustain as a result of his or her participation in any activities, regardless of the specific cause thereof.

I further acknowledge and agree that I have given my consent for the minor to remain in the custody of the Church’s representatives while participating in the Activities.

This Agreement is binding on the minor’s heirs, successors, and personal representatives.

Dated: \_\_\_\_\_ Signed: \_\_\_\_\_  
*On behalf of the minor*

Dated: \_\_\_\_\_ Signed: \_\_\_\_\_  
*Parent -- Individually*

## MEDICAL TREATMENT AUTHORIZATION AND POWER OF ATTORNEY

In the event the minor suffers an injury or condition during his or her participation in the Activities, including transportation to and from the Activities, which may endanger his or her life, cause disfigurement, physical impairment, or undue discomfort if medical treatment is delayed, and reasonable attempts to contact me and my spouse have been unsuccessful, 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 the minor concerning his or her personal care, medical treatment, hospitalization and health care. This power of attorney and delegation of authority shall terminate when the agent is first able to contact me or my spouse.

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

Dated: \_\_\_\_\_ Minor: \_\_\_\_\_

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